



**REPORT OF THE AUDITOR OF PUBLIC ACCOUNTS
AUDIT OF THE CABINET FOR HEALTH SERVICES**

**Made as Part of the Statewide Single Audit
of the Commonwealth of Kentucky**

For the Year Ended June 30, 1998

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CONTENTS

	<u>Page</u>
<u>INTRODUCTION</u>	
Audit Approach.....	1
List Of Abbreviations/Acronyms Used In This Report	2
<u>SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS</u>	
Schedule Of Expenditures Of Federal Awards	5
Notes to the Schedule of Expenditures of Federal Awards	9
<u>REPORTS ON COMPLIANCE AND INTERNAL CONTROL</u>	
Report On Compliance And On Internal Control Over Financial Reporting Based On An Audit Of General-Purpose Financial Statements Performed In Accordance With Government Auditing Standards	16
Report On Compliance With Requirements Applicable To Each Major Program And Internal Control Over Compliance In Accordance With OMB Circular A-133.....	18
<u>SCHEDULE OF FINDINGS AND QUESTIONED COSTS</u>	
Section 1 - Summary of Auditor's Results	22
Section 2 - Financial Statement Findings	24
<u>Other Matter Comments Relating To Internal Controls And/Or Compliance:</u>	
<u>FINDING 98-CHS-1:</u> The Cabinet For Health Services Should Improve Controls Over Personnel And Payroll Function	24
<u>FINDING 98-CHS-2:</u> The Cabinet For Health Services Should Improve Control Procedures Over The Medical Assistance Program.....	26
<u>FINDING 98-CHS-3:</u> The Cabinet For Health Services Should Strengthen Controls Over The Kentucky Health Care Program	27
<u>FINDING 98-CHS-4:</u> The Cabinet For Health Services Should Improve Controls Over Providers.....	29
Section 3 - Federal Award Findings and Questioned Costs	
<u>Reportable Conditions Relating To Internal Controls And Compliance:</u>	
<u>FINDING 98-CHS-5:</u> Subrecipient Monitoring Procedures At The Division Of State And Local Health Departments Should Be Improved	31
<u>FINDING 98-CHS-6:</u> The Department Of Public Health Should Develop Written Policies And Procedures For Significant Areas Of The Immunization Program.....	32

CONTENTS (Continued)

Page

Section 3 - Federal Award Findings and Questioned Costs (Continued)

Other Matter Comments Relating To Internal Control And Compliance:

<u>FINDING 98-CHS-7: The Department Of Public Health Should Strengthen Controls Over The Vaccine Inventory System.....</u>	36
<u>FINDING 98-CHS-8: The Department Of Public Health Should Improve Controls Over The Bank Reconciliation Process.....</u>	40
<u>FINDING 98-CHS-9: The Department Of Public Health Should Close Its County Health Central Bank Account.....</u>	41
<u>FINDING 98-CHS-10: The Department For Medicaid Services Should Improve Controls Over Nursing Facilities To Comply With Regulations</u>	45
<u>FINDING 98-CHS-11: The Hospital And Psychiatric Facilities Branch Should Monitor Length Of Stay In Hospitals And Psychiatric Hospitals In Accordance With Federal Regulations</u>	46
<u>FINDING 98-CHS-12: The Department For Mental Health/Mental Retardation Services Should Strengthen Internal Controls And File Maintenance Procedures Within The SCI Waiver Program.....</u>	47
<u>FINDING 98-CHS-13: The Department For Medicaid Services Should Strengthen Controls Over The Supports For Community Living Waiver.....</u>	52
<u>FINDING 98-CHS-14: The Department For Medicaid Services Should Strengthen Controls Over The Home And Community Based Waiver</u>	56
<u>FINDING 98-CHS-15: The Department For Medicaid Services Should Improve Record Keeping And Monitoring Of HCFA- 1539 Form Certifications</u>	61
<u>FINDING 98-CHS-16: The Department For Medicaid Services Should Strengthen Controls Over Monitoring The Home And Community Based Waiver.....</u>	63
<u>FINDING 98-CHS-17: The Department For Mental Health/Mental Retardation Services Should Create A Written Policy And Procedure Manual Including Statistical Valid Sampling Procedures For On-Site Reviews Of The Supports For Community Living Waiver.....</u>	69
<u>FINDING 98-CHS-18: The Department For Medicaid Services Should Ensure That Ad Hoc Reports From Unisys Are Timely And Accurate.....</u>	71
<u>FINDING 98-CHS-19: The Department For Medicaid Services Should Implement A System To Generate Random Selection Of Edit Check Denied Claims In The Medicaid Management Information System.....</u>	72

CONTENTS (Continued)

	<u>Page</u>
Section 3 - Federal Award Findings and Questioned Costs (Continued)	
<u>Other Matter Comments Relating To Internal Control And Compliance:</u>	
<u>FINDING 98-CHS-20:</u> The Department For Public Health Should Develop A Formal Disaster Recovery Plan.....	74
<u>FINDING 98-CHS-21:</u> The Commission For Children With Special Health Care Needs Should Adhere To Established Internal Control Procedures	76
<u>FINDING 98-CHS-22:</u> The Department Of Public Health Should Improve Controls Over The Special Supplemental Nutrition Program For Women, Infants, And Children	78
<u>SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS</u>	
Summary Schedule Of Prior Audit Findings	80

INTRODUCTION

CABINET FOR HEALTH SERVICES
INTRODUCTION
FOR THE YEAR ENDED JUNE 30, 1998

Introduction

The Auditor of Public Accounts, acting as principal auditor in conjunction with various certified public accounting firms, annually performs a Statewide Single Audit of the Commonwealth of Kentucky, this audit allows the Commonwealth to comply with federal audit requirements as set forth in the Single Audit Act of 1984, as amended by Public Law 104-156, and the regulations contained in the U.S. Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Public Law 104-156, referred to as the Single Audit Act Amendments of 1996, is effective for fiscal years beginning after June 30, 1996.

Audit Approach

Our audit was conducted in accordance with generally accepted auditing standards, *Government Auditing Standards*, the Single Audit Act Amendments of 1996, and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. The scope of the statewide single audit for the year ended June 30, 1998, included:

- An audit of the general-purpose financial statements and required supplementary schedules in accordance with generally accepted government auditing standards;
- An audit of supplementary Schedule of Expenditures of Federal Awards in accordance with generally accepted government auditing standards;
- An audit of the internal controls applicable to the Commonwealth of Kentucky's organizational units and administrative bodies, to the extent necessary to consider and test the internal accounting and administrative control systems as required by generally accepted government auditing standards, the Single Audit Act Amendments of 1996, and the provisions of OMB Circular A-133; and
- A selection and testing of transactions and records relating to each major federal financial assistance program to obtain reasonable assurance that the Cabinet for Health Services administers its major federal financial assistance programs in compliance with laws and regulations for which noncompliance could have a material effect on the allowability of program expenditures or on the Commonwealth of Kentucky's general-purpose financial statements.

The Auditor of Public Account's office conducted the audit of the internal control focusing on the following objectives:

- Considering the internal control at the Cabinet for Health Services in order to determine auditing procedures on the General-Purpose Financial Statements of the Commonwealth of Kentucky.
- Determining if the Cabinet for Health Services has an internal control to provide reasonable assurance that it is managing the federal assistance programs in compliance with applicable laws and regulations.

**CABINET FOR HEALTH SERVICES
INTRODUCTION
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

List of Abbreviations/Acronyms Used In This Report

AIDS	Acquired Immunodeficiency Virus Syndrome
AIS/MR	Alternative Intermediate Services for the Mentally Retarded
APA	Auditor of Public Accounts
CCSHCN	Commission for Children with Special Health Care Needs
CDC	Center for Disease Control
CFDA	Catalog of Federal Domestic Assistance
CFR	Code of Federal Regulations
CHCBA	County Health Central Bank Account
CHR	Cabinet for Human Resources
CHS	Cabinet for Health Services
CPAS	Claims Processing Assessment System
C&T	Certification & Transmittal
DMH	Department for Mental Health
DMHMRS	Department for Mental Health and Mental Retardation Services
DMS	Cabinet for Health Services, Department for Medicaid Services
DOA	Division of Accounts
DPH	Cabinet for Health Services, Department for Public Health
DSS	Cabinet for Families and Children, Department for Social Services
FY	Fiscal Year
HCB	Home and Community Based
HCBW	Home and Community Based Waiver
HCFA	Health Care Financing Administration
HIV	Human Immunodeficiency Virus
ID	Identification Number
IT	Information Technology
KAR	Kentucky Administrative Regulation
KHCP	Kentucky Health Care Program
KRS	Kentucky Revised Statutes
LAN	Local Area Network
L&R	Licensing & Regulation
LHD	Local Health Department
LOC	Level of Care
LOS	Length of Stay
MAID#	Medicaid Number
MAP	Medical Assistance Program
MARS	Management Administrative Reporting System
MHMRS	Mental Health and Mental Retardation Services
MMIS	Medicaid Management Information System
MRS	Mental Retardation Services
NF	Nursing Facilities
OMB	United States Office of Management and Budget
OPS	Office of Program Support
OSCAR	Online Survey Certification and Reporting System
PCT	Personal Service Contract
POC	Plan of Correction
PRO	Peer Review Organization

**COMMONWEALTH OF KENTUCKY
INTRODUCTION
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

List of Abbreviations/Acronyms Used In This Report (Continued)

RA	Remittance Advice
RFP	Request For Proposal
RN	Registered Nurse
SC	Support Coordinator
SCL	Supports for Community Living
SFY	State Fiscal Year
SNF	Skilled Nursing Facilities
SSWAK	Single Statewide Audit of Kentucky
STARS	State Accounting and Reporting System
TCN	Transaction Code Number
VACMAN	Vaccine Software Management System
VFC	Vaccine for Children
USC	United States Code
USDA	United States Department of Agriculture
USDOL	United States Department of Labor
WFDC	Workforce Development Cabinet
WIC	Women, Infants, and Children Program
Y2K	Year 2000

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SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

**CABINET FOR HEALTH SERVICES
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FEDERAL ASSISTANCE PROGRAMS
FOR THE YEAR ENDED JUNE 30, 1998**

STATE AGENCY		PASS-THROUGH GRANTOR'S #	EXPENDITURES	
FEDERAL GRANTOR			CASH	NONCASH
CFDA #/PROGRAM TITLE				
<u>U.S. Department of Agriculture</u>				
Direct Program:				
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children (Note 2) (Note 4)	NA	\$ 82,985,869	
Passed-Through From Cabinet for Families and Children:				
10.561	State Administrative Matching Grants for Food Stamp Program (Note 2)	NA	246,725	
<u>U.S. Environmental Protection Agency</u>				
Direct Programs:				
66.032	State Indoor Radon Grants (Note 4)	NA	271,444	
66.707	TSCA Title IV State Lead Grants - Certification of Lead-Based Paint Professionals	NA	241,815	
<u>U.S. Department of Energy</u>				
Passed-Through From Natural Resources and Environmental Protection Cabinet:				
81.502	Paducah Gaseous Diffusion Plant Environmental Monitoring and Oversight (Note 4)	NA	177,746	
<u>U.S. Federal Management Emergency Agency</u>				
Direct Programs:				
83.539	Crisis Counseling (Note 4) (Note 6)	NA		
83.544	Public Assistance Grants (Note 4) (Note 6)	NA		
<u>U.S. Department of Education</u>				
Passed-Through From Department of Education:				
84.181	Special Education - Grants for Infants and Families with Disabilities (Note 4)	NA	2,980,333	
84.186	Safe and Drug-Free Schools and Communities - State Grants (Note 4)	NA	1,110,561	

**CABINET FOR HEALTH SERVICES
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FEDERAL ASSISTANCE PROGRAMS
FOR THE YEAR ENDED JUNE 30, 1998**

STATE AGENCY		PASS-THROUGH GRANTOR'S #	EXPENDITURES	
FEDERAL GRANTOR	CFDA #/PROGRAM TITLE		CASH	NONCASH
<u>U.S. Department of Health and Human Services</u>				
Direct Programs:				
93.110	Maternal and Child Health Federal Consolidated Programs	NA	\$ 871,248	
93.116	Project Grants and Cooperative Agreements for Tuberculosis Control Programs (Note 4) (Note 5)	NA	990,193	\$ 69,051
93.119	Grants for Technical Assistance Activities Related to the Block Grant for Community Mental Health Services - Technical Assistance Centers for Evaluation (Note 4)	NA	175,923	
93.125	Mental Health Planning and Demonstration Projects (Note 4)	NA	60,423	
93.130	Primary Care Services - Resource Coordination and Development Primary Care Offices (Note 4)	NA	101,852	
93.150	Projects for Assistance in Transition from Homelessness (PATH) (Note 4)	NA	319,770	
93.194	Community Prevention Coalitions (Partnership) Demonstration Grant (Note 4)	NA	172,561	
93.217	Family Planning - Services	NA	3,901,434	
93.235	Abstinence Education	NA	567,566	
93.262	Occupational Safety and Health Research Grants (Note 4)	NA	20,815	
93.268	Immunization Grants (Note 2) (Note 3) (Note 4) (Note 5)	NA	2,644,676	10,744,842
93.283	Centers for Disease Control and Prevention - Investigations and Technical Assistance (Note 4)	NA	303,380	
93.399	Cancer Control	NA	30,684	
93.630	Developmental Disabilities Basic Support and Advocacy Grants (Note 4)	NA	1,268,757	
93.777	State Survey and Certification of Health Care Providers and Suppliers (Note 2)	NA	3,211,943	
93.778	Medical Assistance Program (Note 2)	NA	1,848,432,452	
93.917	HIV Care Formula Grants	NA	1,933,683	

See accompanying notes to the Schedule of Expenditures of Federal Awards

**CABINET FOR HEALTH SERVICES
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FEDERAL ASSISTANCE PROGRAMS
FOR THE YEAR ENDED JUNE 30, 1998**

STATE AGENCY		PASS-THROUGH GRANTOR'S #	EXPENDITURES	
FEDERAL GRANTOR			CASH	NONCASH
CFDA #/PROGRAM TITLE				
<u>U.S. Department of Health and Human Services (Continued)</u>				
Direct Programs (Continued):				
93.931	Demonstration Grants to States for Community Scholarships (Note 4)	NA	20,788	
93.940	HIV Prevention Activities - Health Department Based (Note 5)	NA	\$ 1,842,626	\$ 64,877
93.944	Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance	NA	123,897	
93.958	Block Grants for Community Mental Health Services (Note 4)	NA	3,615,624	
93.959	Block Grants for Prevention and Treatment of Substance Abuse (Note 2) (Note 4)	NA	16,079,947	
93.977	Preventive Health Services - Sexually Transmitted Diseases Control Grants (Note 5)	NA	369,225	75,591
93.988	Cooperative Agreements for State-Based Diabetes Control Programs and Evaluation of Surveillance Systems	NA	288,194	
93.991	Preventive Health and Health Services Block Grant (Note 4)	NA	2,753,710	
93.994	Maternal and Child Health Services Block Grant to the States (Note 4)	NA	7,233,910	
NA	National Institute of Health - Stroke Belt Initiative (Note 6)	NA		
Passed-Through From Cabinet for Families and Children:				
93.558	Temporary Assistance for Needy Families (Note 2)	NA	85,200	
93.563	Child Support Enforcement (Note 2)	NA	383	
93.568	Low-Income Home Energy Assistance (Note 2)	NA	3,163	
93.569	Community Services Block Grant	NA	3,477	
93.575	Child Care and Development Block Grant	NA	604,116	
93.667	Social Services Block Grant (Note 2)	NA	885,614	
93.982	Mental Health Disaster Assistance and Emergency Mental Health (Note 4)	NA	502,105	

See accompanying notes to the Schedule of Expenditures of Federal Awards

**CABINET FOR HEALTH SERVICES
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FEDERAL ASSISTANCE PROGRAMS
FOR THE YEAR ENDED JUNE 30, 1998**

STATE AGENCY		PASS-THROUGH GRANTOR'S #	EXPENDITURES	
FEDERAL GRANTOR			CASH	NONCASH
CFDA #/PROGRAM TITLE				
<u>U.S. Corporation for National and Community Service</u>				
Direct Program:				
94.011	Foster Grandparent Program (Note 4)	NA	451,905	
<u>U.S. Social Security Administration</u>				
Direct Program:				
96.001	Social Security - Disability Insurance (Note 2)	NA	1,381	
Subtotal Cabinet For Health Services			\$ 1,988,495,259	\$11,104,361

See accompanying notes to the Schedule of Expenditures of Federal Awards

**CABINET FOR HEALTH SERVICES
NOTES TO THE SCHEDULE OF
EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 1998**

Note 1 - Purpose of the Schedule and Significant Accounting Policies

Purpose of the Schedule – OMB Circular A-133, “Audits of States, Local Governments, and Non-Profit Organizations,” requires a Schedule of Expenditures of Federal Awards showing each federal financial assistance program as identified in the Catalog of Federal Domestic Assistance (CFDA).

Basis of Presentation – The accompanying Schedule of Expenditures of Federal Awards is presented in accordance with OMB Circular A-133. As defined in that Circular, “Federal financial assistance means assistance that non-federal entities receive or administer in the form of grants, loans, loan guarantees, property (including donated surplus property), cooperative agreements, interest subsidies, insurance, food commodities, direct appropriations, and other assistance, but does not include amounts received as reimbursement for services rendered to individuals as described in Sections 205(h) and 205(i).” Accordingly, the accompanying schedule includes the Cabinet for Health Services’ cash and noncash federal financial assistance programs for the year ended June 30, 1998. Those programs that have not been assigned a catalog number, or for which the catalog number was not available, have been shown either at the bottom of the relevant federal grantor subheading or under the “Other Federal Assistance” subheading.

Reporting Entity – The Cabinet for Health Services is an organizational unit of the Commonwealth of Kentucky as defined by KRS 12.010 and is included in the Commonwealth of Kentucky entity for financial reporting purposes. The accompanying Schedule of Expenditure of Federal Awards of the Cabinet for Health Services presents only that portion of the federal financial assistance of the Commonwealth of Kentucky that is attributable to the transactions of the Cabinet for Health Services.

Basis of Accounting – The accompanying Schedule of Expenditures of Federal Awards – Cash Assistance Programs is presented on the basis of cash disbursements as modified by the application of KRS 45.229. Consequently, certain expenditures are recorded in the accounts only when cash is disbursed.

KRS 45.229 provides that the Finance and Administration Cabinet may, “... for a period of thirty (30) days after the close of any fiscal year, draw warrants against the available balances of appropriations made for that fiscal year, for the payment of expenditures incurred during that year or in fulfillment of contracts properly made during the year, but for no other purpose.” However, there is an exception to the application of KRS 45.229 in that regular payroll expenses incurred during the last pay period of the fiscal year are charged to the next year.

The Commonwealth’s general-purpose financial statements are presented on the accrual/modified accrual basis of accounting. Therefore, the Schedule of Expenditures of Federal Awards – Cash Assistance Programs may not be directly traceable to the general-purpose financial statements in all cases.

**CABINET FOR HEALTH SERVICES
NOTES TO THE SCHEDULE OF
EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

Note 1 - Purpose of the Schedule and Significant Accounting Policies (Continued)

Basis of Accounting (Continued)

The noncash expenditures presented on this Schedule represent the noncash assistance expended by the Cabinet for Health Services during the period July 1, 1997 through June 30, 1998, using the method or basis of valuation as described in the notes to the Schedule of Expenditures of Federal Awards for each program. These noncash assistance programs are not reported in the Commonwealth's general-purpose financial statements for the year ended June 30, 1998.

Inter-agency Activity – Certain transactions relating to federal financial assistance may appear in the records of more than one state agency. To avoid the overstatement of federal expenditures, the following policies were adopted for the presentation of the Commonwealth's Schedules of Expenditures of Federal Awards:

- (a) Federal moneys may be received by one state agency (primary state agency – recipient) and passed through to another state agency (secondary state agency – subrecipient) where the moneys are expended. This inter-agency activity is reported in the Schedules of Expenditures of Federal Awards as follows:
 - Under the primary state agency, the federal program is reported as a direct program. However, the transfer of money to the secondary state agency is not included in the primary state agency's expenditures.
 - Under the secondary state agency, the federal program is reported as a pass-through program. The expenditure of the transferred moneys is reported in the secondary agency's expenditures.

Because the schedules exclude federal financial assistance related to state universities, when a state agency passes federal moneys to a state university, this is reported in the schedules as an expenditure of that state agency.

- (b) Federal moneys received by a state agency and used to purchase goods or services from another state agency are reported in this schedule only by the purchasing agency as an expenditure.

**CABINET FOR HEALTH SERVICES
NOTES TO THE SCHEDULE OF
EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

Note 2 - Type A Programs

Under the provision of the Single Audit Act Amendments of 1996 and OMB Circular A-133, federal programs must be defined as Type A or Type B programs. For the Statewide Single Audit of the Commonwealth of Kentucky, a Type A program must have expended over \$12 million. All other programs are Type B programs.

Clusters are a group of closely related programs sharing common compliance requirements. A cluster of programs must be considered as one program for determining Type A programs. In relation to noncash federal financial assistance programs, this threshold is generally applied to the amount of assistance expended during the year as presented on the noncash portion of the Schedule of Expenditures of Federal Awards, plus any cash expenditures under the same CFDA designation.

The Cabinet for Health Services had three cash programs and one cash/noncash program that met the Type A major program definition and one high-risk Type B program that was audited as a major program for the year ended June 30, 1998. The Cabinet identified one cluster, Medicaid, which included more than one federal program, among the Type A programs. These Type A programs were:

CFDA #	Federal Program Name	Expenditure
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children	\$ 82,985,869
93.778	Medical Assistance Program	1,848,432,452
93.959	Block Grants for Prevention and Treatment of Substance Abuse	16,079,947
93.994	Maternal and Child Health Services Block Grant to the States	11,582,212
93.268	Immunization Grants	13,389,518

Note 3 - Activity Occurring in Noncash Programs With Inventoriable Items

The Cabinet for Health Services is a pass-through entity for local organizations. The Cabinet receives, stores, and distributes vaccine, needle, and syringe inventory items related to the Immunization Grants (CFDA #93.268) program.

No ending inventory balance could be calculated, with certainty, due to inconsistent and inaccurate inventory counts and the lack of disbursement records. The basis for the noncash vaccine expenditures is the National Immunization Program CDC Orders Approved Report. See finding 98-CHS-7 in the Schedule of Findings and Questioned Costs for further discussion.

**CABINET FOR HEALTH SERVICES
NOTES TO THE SCHEDULE OF
EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

Note 4 - Subrecipient Activity

A subrecipient is a non-federal entity that expends federal awards received from a pass-through entity to carry out a federal program. The following list summarizes the amount of federal funds sent to subrecipients.

CFDA #	Federal Program Name	Amount Provided To Subrecipient
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children	\$ 924,173
66.032	State Indoor Radon Grants	44,711
81.502	Paducah Gaseous Diffusion Plant Environmental Monitoring and Oversight	4,680
84.181	Special Education – Grants for Infants and Families with Disabilities	554,882
84.186	Safe and Drug-Free Schools and Communities - State Grants	3,531,187
93.116	Project Grants and Cooperative Agreements for Tuberculosis Control Programs	44,100
93.119	Grants for Technical Assistance Activities Related to the Block Grant for Community Mental Health Services - Technical Assistance Centers for Evaluation	375,518
93.125	Mental Health Planning and Demonstration Projects	75,255
93.130	Primary Care Services – Resources Coordination and Development Primary Care Offices	100,000
93.150	Projects for Assistance in Transition From Homelessness (PATH)	205,433
93.194	Community Prevention Coalitions (Partnership) Demonstration Grant	25,732
93.262	Occupational Safety and Health Research Grants	79,046
93.268	Immunization Grants	475,037
93.283	Centers for Disease Control and Prevention – Investigations and Technical Assistance	84,453
93.630	Developmental Disabilities Basic Support and Advocacy Grants	121,616

**CABINET FOR HEALTH SERVICES
NOTES TO THE SCHEDULE OF
EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

Note 4 - Subrecipient Activity (Continued)

CFDA #	Federal Program Name	Amount Provided To Subrecipient
93.919	Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs	\$ 258,413
93.931	Demonstration Grants To States for Community Scholarships	54,844
93.958	Block Grants for Community Mental Health Services	5,316,302
93.959	Block Grants for Prevention and Treatment of Substance Abuse	8,849,265
93.982	Mental Health Disaster Assistance and Emergency Mental Health (Mental Health Disaster Assistance)	5,983
93.991	Preventive Health and Health Services Block Grant	2,041,523
93.994	Maternal and Child Health Services Block Grant to the States	868,474
94.011	Foster Grandparent Program	164,606
	Total	\$24,215,233

**CABINET FOR HEALTH SERVICES
NOTES TO THE SCHEDULE OF
EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

Note 5 - Noncash Expenditure Programs

The Cabinet for Health Services had 5 noncash programs for the year ended June 30, 1998. These noncash programs and a description of the method/basis of valuation follow:

CFDA #	Federal Program Name	Expenditure	Method/Basis of Valuation
93.116	Project Grants and Cooperative Agreements for Tuberculosis Control Programs	\$ 69,051	Per authorized award for personnel costs and travel.
93.268	Immunization Grants	10,744,842	Per authorized award for personnel and vaccine costs.
93.919	Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs	150,000	Per authorized personnel and other costs and travel.
93.940	HIV Prevention Activities – Health Department Based	64,877	Per authorized personnel and other costs.
93.977	Preventive Health Services – Sexually Transmitted Diseases Control Grants	75,591	Per authorized personnel costs and travel.

Note 6 - Zero Expenditure Programs

These programs had no expenditures during the year ended June 30, 1998. They included programs with no activity during the year, such as old programs not officially closed out or new programs issued late in the fiscal year. They also included programs with activity other than expenditures.

REPORTS ON COMPLIANCE AND INTERNAL CONTROL



Edward B. Hatchett, Jr. Auditor of Public Accounts

To the People of Kentucky
Honorable Paul E. Patton, Governor
Jimmy D. Helton, Secretary
Cabinet for Health Services

Report On Compliance And On Internal Control Over Financial Reporting Based On An Audit Of General-Purpose Financial Statements Performed In Accordance With Government Auditing Standards

We have audited the general-purpose financial statements of the Commonwealth of Kentucky as of and for the year ended June 30, 1998, and have issued our report thereon dated January 30, 1999. We have audited receipts, expenditures, payroll, accounts receivable, accounts payable, preaudit authority, purchasing authority, and judgements and contingencies of the Cabinet for Health Services, and organizational unit of the Commonwealth of Kentucky as defined by KRS 12.010. We conducted our audit in accordance with generally accepted government auditing standards and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States.

Compliance

As part of obtaining reasonable assurance about whether the Commonwealth of Kentucky's financial statements are free of material misstatement, we performed tests of the Cabinet for Health Services' compliance with certain provisions of laws, regulations, contracts and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under Government Auditing Standards. However, we noted a certain immaterial instance of noncompliance that we have reported in the accompanying schedule of findings and questioned costs as Finding 98-CHS-4.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Cabinet for Health Services' internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgement, could adversely affect the Cabinet for Health Services' ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements. Reportable conditions are described in the accompanying Schedule of Findings and Questioned Costs as items 98-CHS-1, 98-CHS-2, and 98-CHS-3.

To the People of Kentucky
Honorable Paul E. Patton, Governor
Jimmy D. Helton, Secretary
Cabinet for Health Services
Report On Compliance And On Internal Control Over
Financial Reporting Based On An Audit Of General-Purpose
Financial Statements Performed In Accordance With Government Auditing Standards
(Continued)

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions, and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. We noted no matters involving the internal control over financial reporting and its operation that we consider to be material weaknesses.

However, we noted other matters involving the internal control over financial reporting that we have reported in the accompanying Schedule of Findings and Questioned Costs as items 98-CHS-1, 98-CHS-2, 98-CHS-3.

This report is intended solely for the information and use of management and applicable federal awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties. However, this report, upon release by the Auditor of Public Accounts, is a matter of public record and its distribution is not limited.

Respectfully submitted,



Edward B. Hatchett, Jr.
Auditor of Public Accounts

Audit fieldwork complete –
January 30, 1999



Edward B. Hatchett, Jr.
Auditor of Public Accounts

To the People of Kentucky
Honorable Paul E. Patton, Governor
Jimmy D. Helton, Secretary
Cabinet for Health Services

Report On Compliance With Requirements
Applicable To Each Major Program And Internal Control
Over Compliance In Accordance With OMB Circular A-133

Compliance

As part of the Statewide Single Audit of the Commonwealth of Kentucky, we have audited the compliance of the Cabinet for Health Services, with the types of compliance requirements described in the *U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement* that are applicable to each of its major federal programs for the year ended June 30, 1998. The Cabinet for Health Services' major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs is the responsibility of the Cabinet for Health Services' management. Our responsibility is to express an opinion on the Cabinet for Health Services' compliance based on our audit.

We conducted our audit of compliance in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Cabinet for Health Services' compliance with those requirements and performing such other procedures, as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination on the Cabinet for Health Services' compliance with those requirements.

In our opinion, based on our audit, the Cabinet for Health Services complied, in all material respects, with the requirements referred to above that are applicable to each of its major federal programs for the year ended June 30, 1998. However, the results of our auditing procedures disclosed instances of noncompliance with those requirements, which are required to be reported in accordance with OMB Circular A-133 and which are described in the accompanying Schedule of Findings and Questioned Costs as item 98-CHS-5

To the People of Kentucky
Honorable Paul E. Patton, Governor
Jimmy D. Helton, Secretary
Cabinet for Health Services
Report On Compliance With Requirements
Applicable To Each Major Program And Internal Control
Over Compliance In Accordance With OMB Circular A-133
(Continued)

Internal Control Over Compliance

The management of the Cabinet for Health Services is responsible for establishing and maintaining effective internal control over compliance with requirements of laws, regulations, contracts and grants applicable to federal programs. In planning and performing our audit, we considered the Cabinet for Health Services' internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133.

We noted certain matters involving the internal control over compliance and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over compliance that, in our judgment, could adversely affect the Cabinet for Health Services' ability to administer a major federal program in accordance with applicable requirements of laws, regulations, contracts, and grants. Reportable conditions are described in the accompanying schedule of findings and questioned costs as items 98-CHS-5, 98-CHS-6, and 98-CHS-7.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with applicable requirements of laws, regulations, contracts and grants that would be material in relation to a major federal program being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over compliance would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, we believe that one of the reportable conditions described above is a material weakness. This material weakness is described in the accompanying schedule of findings and questioned costs as item 98-CHS-7.

We also noted other matters involving the internal control over compliance that we have reported in the accompanying schedule of findings and questioned costs.

Schedule of Expenditures of Federal Awards

We have audited the general-purpose financial statements of Commonwealth of Kentucky as of and for the year ended June 30, 1998, and have issued our report thereon dated January 30, 1999. Our audit was performed for the purpose of forming an opinion on the Commonwealth of Kentucky's general-purpose financial statements taken as a whole. The accompanying schedule of expenditures of federal awards of the Cabinet for Health Services is presented for the purposes of additional analysis as required by OMB Circular A-133 and is not a required part of the Commonwealth of Kentucky's general-purpose financial statements. Such information has been subjected to the auditing procedures applied in the audit of the general-purpose financial statements.

To the People of Kentucky
Honorable Paul E. Patton, Governor
Jimmy D. Helton, Secretary
Cabinet for Health Services
Report On Compliance With Requirements
Applicable To Each Major Program And Internal Control
Over Compliance In Accordance With OMB Circular A-133
(Continued)

As described in Note 1, the Schedule of Expenditures of Federal Awards of the Cabinet for Health Services is intended to present only that portion of the expenditures of federal awards of the Commonwealth of Kentucky that is attributable to the transactions of the Cabinet for Health Services.

The general-purpose financial statements of the Commonwealth of Kentucky are prepared on the accrual/modified accrual basis of accounting. However, as described in Note 1, the Schedule of Expenditures of Federal Awards of the Cabinet for Health Services is prepared on the basis of cash disbursements as modified by the application of KRS 45.229. Consequently, certain expenditures are recorded in the accounts only when cash is disbursed. Accordingly, the Schedule of Expenditures of Federal Awards is not intended to present the expenditures of federal awards in conformity with generally accepted accounting principles.

In our opinion, except for the effect of the application of a different basis of accounting as explained above, the Schedule of Expenditures of Federal Awards of the Cabinet for Health Services is fairly stated, in all material respects, in relation to the Commonwealth of Kentucky's general-purpose financial statements taken as a whole.

This report is intended solely for the information and use of management and applicable federal awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties. However, this report, upon release by the Auditor of Public Accounts, is a matter of public record and its distribution is not limited.

Respectfully submitted,



Edward B. Hatchett, Jr.
Auditor of Public Accounts

Audit fieldwork complete –
July 23, 1999

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SCHEDULE OF FINDINGS AND QUESTIONED COSTS

CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS

FOR THE YEAR ENDED JUNE 30, 1998

SECTION 1 – SUMMARY OF AUDITOR’S RESULTS

Financial Statement Accounts and Schedule of Expenditures of Federal Awards

Financial Statement Accounts: We issued a qualified opinion on the Commonwealth of Kentucky’s general-purpose financial statements as of and for the year ended June 30, 1998 because we were unable to verify evidence regarding year 2000 disclosures. The Cabinet for Health Services was included in our audit procedures of the general-purpose financial statements.

Schedule of Expenditures of Federal Awards: We issued a qualified opinion on the Cabinet for Health Services’ Schedule of Expenditures of Federal Awards because the schedule was presented on a basis of accounting that was not in conformance with generally accepted accounting principles. The opinion was issued in relation to the Commonwealth of Kentucky’s general-purpose financial statements taken as a whole.

Internal Control Over Financial Reporting: Our consideration of the Cabinet for Health Services’ internal control over financial reporting disclosed no material weaknesses.

Compliance: In relation to the audit of the Cabinet for Health Services’ accounts that we audited, and the Schedule of Expenditures of Federal Awards, the results of our tests disclosed no instances of noncompliance that are required to be reported under generally accepted government auditing standards

Federal Awards

Internal Control Over Compliance: Our consideration of the Cabinet for Health Services’ internal control over compliance disclosed three reportable conditions. We believe that one of the reportable conditions is a material weakness.

Compliance: We issued an unqualified opinion on the Cabinet for Health Services’ compliance with the requirements applicable to each of its major federal programs. However, the results of our auditing procedures disclosed one instance of noncompliance with those requirements, which are required to be reported in accordance with OMB Circular A-133, section 510(a). We also noted \$302,180 of questioned costs for providers eligibility in the Medical Assistance Program.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 1 – SUMMARY OF AUDITOR’S RESULTS (Continued)

Identification of Major Programs

OMB Circular A-133 defines a major program (Type A program) as “a Federal program determined by the auditor to be a major program in accordance with section __.520 or a program identified as a major program by the Federal awarding agency or pass-through entity in accordance with section __.215(c).” Section __.520 states that “The auditor shall use a risk-based approach to determine which Federal programs are major programs.”

OMB Circular A-133 defines Type B programs as programs “which are high-risk using professional judgement and the criteria in section __.525.”

The following is a list of Type A and Type B programs audited:

CFDA #	Federal Program or Cluster	Amount
<u>Type A Programs:</u>		
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children	\$ 82,985,869
* 93.778	Medicaid Assistance Program	1,848,432,452
93.268	Immunization Grants	3,389,518
93.959	Block Grants for Prevention and Treatment of Substance Abuse	16,079,947
<u>Type B Programs:</u>		
@ 93.994	Maternal and Child Health Services Block Grant to the States	11,582,212

Identified clusters include:

*CFDA # 93.775 and 93.777 – Medicaid Cluster

@ Includes \$4,348,302 from the Commission for Children With Special Health Care Needs. This is a Type B program audited as a major program because of assessed risk.

Dollar Threshold Used to Distinguish Between Type A and Type B Programs

The maximum dollar threshold used to distinguish between Type A and Type B Programs was \$12 million.

Auditee Qualify as Low-Risk Auditee?

The Commonwealth of Kentucky did not qualify as a low-risk auditee.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 2 – FINANCIAL STATEMENT FINDINGS

Other Matter Comments Relating To Internal Control And/Or Compliance:

FINDING 98-CHS-1: The Cabinet For Health Services Should Improve Controls Over Personnel And Payroll Function

During our testing in the payroll and personnel division of the Department for Mental Health and Mental Retardation, we noted the following weaknesses in internal control:

- Two supervisors that had signed timesheets did not have signature cards on file.
- On form Authorization For Personnel/Position Action Request, signature is only filed when the Personnel Department requests it to be filed. The last time this form was filed was March 1, 1996.
- The procedure to key in Form CHR-7 was performed at different times and in different areas as a result, there was a lack of consistency in the procedure.
- The Form CHR-7 should be stamped with Executive Director Marcia Morgan after being reviewed and entered into the system.

As a result, an unauthorized employee may receive a paycheck or a supervisor may sign a timesheet not knowing if the hours claimed were correct. Also, an unauthorized signature may sign a P-1.

Effective internal control dictates that timesheets be signed by an authorized person to ensure that all timesheets are correct. Current authorized signature cards should be maintained. When an employee is hired, dismissed, or otherwise changes positions, all records should be updated immediately.

Recommendation

We recommend that all supervisors authorized to sign timesheets have signature cards on file. Also, we recommend when a new employee is hired or given the position of authorization, a signature form is completed and submitted to Personnel. An immediate notice of when an employee is terminated or dismissed from the position of authorization must be given.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 2 – FINANCIAL STATEMENT FINDINGS (Continued)

Other Matter Comments Relating To Internal Control And/Or Compliance: (Continued)

FINDING 98-CHS-1: The Cabinet For Health Services Should Improve Controls Over Personnel And Payroll Function (Continued)

Management's Response and Corrective Action Plan

Signature Authorization is a very important mechanism that must be in place to officially designate and hold supervisors accountable for their employees' regular and overtime hours worked and for any leave authorized during each pay period. To assure authorization cards are maintained current, timekeepers throughout the Cabinet are responsible for securing a signature card the time a new supervisor assumes responsibility for authorizing time and attendance. The signed cards are then approved by the next level of supervision and forwarded to the Payroll Administrator. These cards are maintained until notice is given that a supervisor has been replaced at which time the old signature card is filed in the inactive file and the new signature card is inserted. Each pay period, the Time and Attendance Specialist randomly audits timesheets for authorized signatures. In addition, there is a semi-monthly reminder included with payroll instructions that will now regularly include an alert to timekeepers to obtain and maintain current timesheet signature files.

I have been advised that MHMRS payroll staff took immediate corrective steps at the time of discovery that two time sheets were not properly authorized.

Signature Authorization is a very important mechanism that must be in place to officially designate and hold personnel accountable in a variety of processing tasks. There are at least six distinct authorizations granted that relate to Personnel/Payroll actions. These are 1) to authorize employee time and attendance reports, 2) to initiate a personnel/position action (CHS-7, now OPS-7), 3) to affirm to the Personnel Cabinet that original transcripts of an employee or applicant have been reviewed, 4) to advise the Personnel Cabinet of Agency staff granted authority to sign Personnel/Payroll documents on behalf of the Agency, 5) to advise the Finance and Administration Cabinet of Agency staff granted authority to sign a Request for Refund (DOA-26) and/or Payroll Voucher (DOA-27).

The Authorization for Personnel/Position Action Request (aka CHR-7 and OPS-7) is an internal document used for initiation of action and preparation of the P-1. It is not filed with the Personnel Cabinet. We do have an internal form to confirm the authorization signature of individuals to initiate personnel/position actions. It is true that the last documents on file designate signature authority for DMHMRS officials were in March 1, 1996. We have taken steps to request and update the necessary signature authorization forms.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 2 – FINANCIAL STATEMENT FINDINGS (Continued)

Other Matter Comments Relating To Internal Control And/Or Compliance: (Continued)

FINDING 98-CHS-1: The Cabinet For Health Services Should Improve Controls Over Personnel And Payroll Function (Continued)

Management's Response and Corrective Action Plan (Continued)

During the period audited, it is accurate that the MHMRS personnel/payroll office did not have the capability to enter certain actions into the electronic P-I system. Once the action was received and audited by the MHMRS personnel staff, the action was sent to agency personnel/payroll staff at another location for the actual data entry. This situation no longer exists as the MHMRS office now has the technology to perform its own data entry.

In the past, the CHR-7 was stamped with three different notations. Once received, a Personnel Specialist would review it and stamp it as authorized by Marcia Morgan. The "audited" stamp was then used to affirm that the codes and data on the form complied with requirements and were correct. The staff person who actually entered the action into the computer system would stamp it "entered". Changes the office has implemented now place the responsibility for authorizing the action, confirming that the action coding is correct and for keying that action into the system, to staff within the same office. The signature stamp is now used to indicate that the document is approved and has been entered into the system.

FINDING 98-CHS-2: The Cabinet For Health Services Should Improve Control Procedures Over The Medical Assistance Program

UNISYS adjudicates claims for the Medicaid expenditures. During our audit period, the Department for Medicaid Services (DMS) performed a "voluntary" Claims Processing and Assessment System (CPAS) to ensure proper claims processing. DMS's sample selection method used a starting number with fixed intervals to select the samples within each of the categories (e.g. Hospital Services, Long-Term Care Service, etc.). The last claim selected for testing within each category was far below the final number of the claim universe. This selection method resulted in approximately 25 percent of the population having no opportunity of being selected. Additionally, UNISYS selected the sample of claims to test. DMS did not perform a *reconciliation* of the population to ensure that the sample was pulled from the *entire* population of adjudicated claims.

Although CPAS is no longer required by HCFA, Medicaid has elected to use CPAS as a control system. Therefore, management is responsible for insuring that the controls are in place and operating effectively. This comment was addressed in the prior year audit also.

The claims, from which the CPAS samples are selected, are entered by "Recipient Numbered Order" when read into the system. Accordingly, with the limited interval sample selection method used, the higher numbered recipients do not have an equal chance of being selected. Approximately 25 percent of the claims had no chance of being selected or reviewed.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 2 – FINANCIAL STATEMENT FINDINGS (Continued)

Other Matter Comments Relating To Internal Control And/Or Compliance: (Continued)

FINDING 98-CHS-2: The Cabinet For Health Services Should Improve Control Procedures Over The Medical Assistance Program (Continued)

Because the Fiscal Agent pulls the sample and no reconciliation is performed by DMS, the sample could be manipulated to omit or withhold problem areas within the system from DMS's knowledge. This could adversely affect the results of the CPAS testing.

Good internal controls dictate that information received from outside sources be verified for completeness and accuracy. In addition, Part II of the State Medicaid Manual, Chapter 6 states "the sample selection must be performed on a complete sampling frame. A sampling frame for the prescribed sample universe is all Medicaid line items authorized for payment."

Recommendation

We recommend DMS revise their sample selection method for CPAS testing to include the complete sampling frame. We also recommend DMS establish reconciliation procedures to ensure that the sample selected is representative of the entire population/universe. Alternately, DMS might consider pulling the sample from the universe of actual claims paid through STARS.

Management's Response and Corrective Action Plan

The Claims Processing Assessment System is no longer required by HCFA, neither mandatory nor alternate. Attached is the HCFA transmittal notice dated August 13, 1996, notifying the state agencies that CPAS has been discontinued.

Auditor's Response

We are aware that HCFA no longer requires CPAS. However, MAP has elected to use CPAS as a control system, and it is management's responsibility to insure that the controls are in place and operating effectively

FINDING 98-CHS-3: The Cabinet For Health Services Should Strengthen Controls Over The Kentucky Health Care Program

During our review of internal controls over Medicaid expenditures, we examined the disproportionate share payments made under the Kentucky Health Care Program. Agency personnel could not locate supporting documentation for five of the quarterly payments.

According to personnel, files were misplaced due to the numerous times the agency was required to move.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 2 – FINANCIAL STATEMENT FINDINGS (Continued)

Other Matter Comments Relating To Internal Control And/Or Compliance: (Continued)

FINDING 98-CHS-3: The Cabinet For Health Services Should Strengthen Controls Over The Kentucky Health Care Program (Continued)

Without proper supporting documentation, the audit trail for these payments is diminished. Therefore, the data used in calculating the payment could not be verified. In some instances agency personnel redid the calculation and we were able to verify the accuracy of the other payments from support provided to us by the agency for the second quarterly.

However, good internal controls dictate that supporting information be maintained and verified for completeness and accuracy.

Recommendation

We recommend agency maintain documentation to support disproportionate share payments made under the Kentucky Health Care Program.

Management's Response and Corrective Action Plan

The original patient listing from the hospitals for the five payments was in the file cabinet and was supplied to the auditor. The internal document part that was missing was never produced for that payment which was made September 24, 1997.

The procedure in place at that time was to enter the hospital's patient listing into a database. After editing, that data was reproduced in a patient listing that was returned to the hospital with the check for the time period. A copy of that report was not made for the Department's files because of constraints of time caused by a move by DMS. The data was stored on a computer and back-up files were made of that data. Those files could be reproduced if necessary. A simpler method is to look at the hospital's patient listing. If it matches the payment, then that is verification.

The auditor states that "without proper supporting documentation, the audit trail for these payments is diminished" and that the data "cannot be verified". Yes, the data can be verified, but not as timely as if all internal documentation had been produced. As far as I know, that circumstance had not happened prior to that one payment and it has not occurred since I began making payments.

The Department currently maintains sufficient records to document payments.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 2 – FINANCIAL STATEMENT FINDINGS (Continued)

Other Matter Comments Relating To Internal Control And/Or Compliance: (Continued)

FINDING 98-CHS-3: The Cabinet For Health Services Should Strengthen Controls Over The Kentucky Health Program (Continued)

Auditor's Response

Agency personnel told the auditor that the data for the first quarter had been lost. A correcting payment for July 1997 through March 1998 showed payments that had been made for this quarter because these amounts had to be subtracted to arrive at the correct payment for the period. The auditor reviewed documentation for these correcting payments. However, original payments could not be verified from this information. The KHCP computation sheet and reconciliation pages were not in the files; therefore, the auditor could not determine whether original payments were calculated correctly.

FINDING 98-CHS-4: The Cabinet For Health Services Should Improve Controls Over Providers

We examined twenty-five provider files while testing Medicaid expenditures to verify eligible Medicaid providers were rendering services. Files were tested to verify proper forms were filed and signed, a provider license was filed, and the provider was eligible to participate in Medicaid.

Based on our testing, the following exceptions were noted:

- One file did not contain the provider agreement (MAP 343), the provider information form (MAP 344), or a current license.
- A second file did not contain a current license, which is required.

If files or the MMIS are not updated, payments for services could be made to ineligible providers. These same exceptions were also noted during our audit last year.

907 KAR 1:672 Section 2 (4) states: "All applicants for participation shall complete and sign a provider agreement, disclosure of ownership and control interest statement, certification with regard to lobbying activity, pursuant to 31 USC 1352, provider proof of a valid professional license registration, or certificate which allows the applicant to provide the services for which the applicant contracts, and provide any additional clarifying information requested for processing of the application."

MAP 343 (Rev. 1/97) – Provider Agreement states that the provider, "Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medicaid Program policies and procedures governing Title XIX Providers and recipients."

Strong internal controls require that a method be established and maintained which monitors providers on a continuous basis so as to be aware, and utilize only those providers which have satisfied the requirements to be eligible as Medicaid participants.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 2 – FINANCIAL STATEMENT FINDINGS (Continued)

Other Matter Comments Relating To Internal Control And/Or Compliance: (Continued)

FINDING 98-CHS-4: The Cabinet For Health Service Should Improve Controls Over Providers (Continued)

Recommendation

We recommend that all provider files be reviewed and updated for required documents as soon as practical. Failure to do so could allow ineligible providers to be reimbursed.

Management's Response and Corrective Action Plan

This response is a repeat finding and our corrective action plan to address this area is approximately 80 percent implemented. All of the major provider groups have been re-enrolled (physician, dental, etc.). The findings in this area are for relatively minor programs, which have not yet gone through complete provider re-enrollment. All of the missing documentation noted in this report has now been obtained.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

Reportable Conditions Relating To Internal Control And Compliance:

FINDING 98-CHS-5: Subrecipient Monitoring Procedures At The Division Of State And Local Health Departments Should Be Improved

State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.994-Maternal and Child Health Services Block Grant to the States

Federal Agency: Department of Health and Human Services

Pass-Through Agency: Not Applicable

Compliance Area: Subrecipient Monitoring

Amount of Questioned Costs: None

We noted a weakness in the internal controls, which the Division of Resource Management had established to ensure audit compliance with OMB Circular A-133 by the local health departments. There were no desk reviews performed on the local health departments' single audits submitted to the Division. The Desk Review Guide for Single Audits should have been used to perform a review on each audit. During our testing in March 1999, agency personnel indicated that no desk reviews had been performed on the local health departments for State Fiscal Year (SFY) 98, as other projects had taken the time necessary to perform the reviews.

Timely management decisions on audit resolution and monitoring of findings requires that the audit reports of the local health departments be reviewed in accordance with OMB Circular A-133. Previous year's audit response to this comment indicated that "The Department for Public Health requires a final audit report within 120 days of year end with final closing by six months after year end." Without a completed desk review prior to six months after year end, there is no assurance that the audits are properly prepared and reconciled to agency records or that findings are resolved within the required six-month timeframe. There is no mechanism for insuring a quality audit has been performed in a timely fashion.

Subpart D.400d (4) and (5) of OMB Circular A-133 requires the pass-through entity to:

- Ensure that subrecipients expending \$300,000 or more in federal awards during the subrecipients' fiscal year have met the audit requirements of this part for that fiscal year.
- Issue a management decision on audit findings within six months after receipt of the subrecipients audit report and ensure that the subrecipient takes appropriate and timely corrective action.

Recommendation

We recommend the Division of Resource Management review all local health department audit reports in accordance with the Desk Review Guide for Single Audit Reports to ensure all applicable audit requirements are met, corrective action is taken when necessary, and reviews of audit reports are performed timely and well documented.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Reportable Conditions Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-5: Subrecipient Monitoring Procedures At The Division Of State And Local Health Departments Should Be Improved (Continued)

Management's Response and Corrective Action Plan

The Department of Public Health has always and will continue to review local health department audits. This review has been performed for all prior years, and will be performed using the "Desk Review Guide for Single Audit Reports" by the accountant or accountants who are responsible for the local health departments for FY 1998. At the time of the APA audit, the review had not been performed for FY 1998 audits due to an internal reorganization of the local Fiscal Management Section in which duties and responsibilities of staff have been shifted. We agree whole-heartedly that audit resolution should be done in a timely manner and will endeavor to complete future desk reviews in a more timely manner.

FINDING 98-CHS-6: The Department Of Public Health Should Develop Written Policies And Procedures For Significant Areas Of The Immunization Program

State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.268-Immunization Grants

Federal Agency: Department of Health and Human Services

Pass-Through Agency: Not Applicable

Compliance Area: Inventory Control and Administrative Cost

Amount of Questioned Costs: None

Various policies and procedures involved in the administration of the Immunization Program were not compiled into a written policies and procedures manual. Several significant areas of the program such as vaccine inventory maintenance, vaccine ordering, and distribution of federal grant administrative funds to local health departments were dependent upon the experience of certain employees.

Even though physical vaccine inventory levels were used to order additional vaccines, there did not appear to be a formal policy requiring how the vaccine inventory should be maintained. Program employees could not determine how or why specific amounts from the federal grant were allocated to the health departments. The Director for the Division of Epidemiology and Health Planning maintained a private system of allocating federal administrative funds to local health centers that was not contained in a written policy. Employee turnover could leave the program unable to complete these processes, resulting in possible cessation of the program.

Good internal control over the Immunization Program requires that the processes involved with the management of the program be consistent. This consistency can only be obtained through a written policy and procedures manual.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Reportable Conditions Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-6: The Department Of Public Health Should Develop Written Policies And Procedures For Significant Areas Of The Immunization Program (Continued)

Recommendation

We recommend the Immunization Program compile a policy and procedures manual that encompasses all aspects of management of the Immunization Program. Such a manual will transcend an employee's specific knowledge of the various program processes and ensure consistent program operations.

Management's Response and Corrective Action Plan

The Immunization Program began using VACMAN to order vaccines in January 1994, but the Program did not start using VACMAN to maintain a perpetual inventory until July 6, 1998. Prior to July 6, 1998, the inventory on hand balances on VACMAN included only vaccine shipments that had been received by the Vaccine Depot. The VACMAN inventory on hand did not reflect orders shipped from the Depot on July 6, 1998 the Immunization Program began to maintain a perpetual inventory on VACMAN. Obviously the successful start up of a perpetual inventory system is dependent upon obtaining an accurate initial physical inventory. If this is done, as was the case in the beginning of the VACMAN perpetual inventory system, or if shipping errors are not discovered, discrepancies will continue to show up in the system until they are reconciled.

Reorder levels are automatically built into the VACMAN system to assist management in determining vaccine needs. However, because of the seasonal variations in the use of some vaccines, the Immunization Program uses these present levels as flags to determine actual needs.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN

The Immunization Program has attempted to address this problem by:

- 1. Hiring a Coordinator for the Vaccine for Children (VFC) Program (Gary Bevill 1/1/99) who is responsible for implementing quality assurance activities, including vaccine accountability procedures identified in federal grant guidelines.*
- 2. Hiring a Supervisor (Glenn Lewis 3/1/99) who is responsible for overseeing the operations of the Vaccine Depot; taking physical inventories; and developing procedures to eliminate shipping errors.*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Reportable Conditions Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-6: The Department Of Public Health Should Develop Written Policies And Procedures For Significant Areas Of The Immunization Program (Continued)

Management's Response and Corrective Action Plan (Continued)

Several corrective procedures have been initiated since January 1, 1999. They include:

- *Printing a daily VACMAN shipping order summary, including type of vaccine, lot numbers, and quantities of each vaccine to be shipped each day. Only the vaccines, lot numbers and the quantities listed on the daily shipping summary are pulled from the walk-in coolers and stocked in the daily picking refrigerator. Containers were purchases to separate individual provider's orders while they are being prepared for shipment to keep the orders from being mixed. If an order cannot be completely filled or if there are vaccines left in the picking refrigerator after all of the vaccine orders have been packaged and readied for shipment, then a shipping error has occurred and should be corrected before the orders go out. Mr. Lewis has developed a manual perpetual inventory procedure that is compared to the monthly physical inventory and the VACMAN inventory on hand report.*
- *Developing a standard form to be used in taking a physical inventory.*
- *Requiring that the Supervisor of the Vaccine Depot take a physical inventory each month. The physical inventory is compared to the VACMAN Inventory on Hand report and a Discrepancy Report is prepared by the VFC Coordinator. Attempts are made to resolve discrepancies by recounting stock and reviewing receiving reports. If a discrepancy cannot be resolved after two (2) consecutive physical inventories, then an adjustment is made to VACMAN.*
- *Adjustments cannot be made to VACMAN until all efforts to resolve discrepancies have been made. Except for returned vaccines, adjustments cannot be made to VACMAN without the approval of Gary Bevill, VFC Coordinator, or Sandra Gambescia, Immunization Program Manager.*
- *A Vaccine Depot Vaccine Return Form (see attached green form) has been developed which is to be filled out when vaccines are returned to the Vaccine Depot by a VFC provider. The form must be submitted to the Immunization Program. If vaccines reported of the Vaccine Return Form are returned to stock, the VACMAN inventory is adjusted accordingly by Lorraine Moore, VFC Program Procedures Development Specialist.*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Reportable Conditions Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-6: The Department Of Public Health Should Develop Written Policies And Procedures For Significant Areas Of the Immunization Program (Continued)

Management's Response and Corrective Action Plan (Continued)

CORRECTIVE STEPS THAT WILL BE TAKEN

1. *Gary Bevill, VFC Coordinator will write a policies and procedures manual by October 1, 1999. The manual will include specific requirements related to physical inventories (must be taken on first and third Thursday of each month); reporting receipt of vaccines to inventory; unpacking and reporting returned vaccines making adjustments to VACMAN; and correcting shipping errors including follow-up with providers.*
2. *Gary Bevill, VFC Coordinator, and Sandra Gambescia, Immunization Program Manager, will develop written criteria and procedures for reordering vaccines and allocating funds to local health departments. This will be accomplished during the second quarter of FY 99-00.*
3. *Out of state travel approval will be requested for Glenn Lewis, Vaccine Depot Supervisor, to visit another vaccine depot during the first quarter of FY 2000, to observe proper storage, handling, and shipping procedures. The site chosen will be one that is recommended by the Centers for Disease Control and Prevention.*
4. *The Immunization is currently studying vaccine usage by month for the last twelve (12) months for each vaccine. Written reorder levels will be established based on past usage. The reorder levels will utilized unless a disease outbreak or unforeseen circumstance, such as changes in the recommended immunization schedule, vaccine spoilage, or disruption in transportation requires different order levels.*

A system to allocate health funds will be created that is based on population, doses of vaccine administered by the health department, and rate of specific diseases. This system will be written as a formula that can be used annually, and implemented by anyone in the program involved in allocating the federal funds to the local health departments.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Material Weaknesses Relating To Internal Control And Compliance:

FINDING 98-CHS-7: The Department Of Public Health Should Strengthen Controls Over The Vaccine Inventory System

State Agency: Cabinet for Health Services

Federal Program: CFDA: 93.268-Immunization Grants

Federal Agency: U. S. Department of Health and Human Services

Pass-Through Agency: Not Applicable

Compliance Area: Inventory Control

Amount of Questioned Costs: None

Accurate vaccine inventory data could not be obtained from the Immunization Program for reporting inventory balances for the note to the Schedule of Expenditures of Federal Awards. Physical inventory counts of vaccines were not taken on a regular basis (same time each month), and were inaccurate and incomplete. The physical counts did not agree or could not be reconciled to the perpetual inventory records kept in the federally supplied vaccine software management system (VACMAN)) or the manual perpetual inventory records kept by Immunization personnel. A brief review of the procedures used to maintain the manual records indicated those records should be reasonably accurate. However, the vaccine inventory maintained in VACMAN, which was phased-in starting in January 1998, was questionable.

VACMAN did not produce consistent reports when identical requests were made at different times. Vaccine inventory totals that were provided by the agency for the beginning and ending inventory for fiscal year 1998 were not consistent. Two printouts of the July 1, 1997 inventory and two for the June 30, 1998 inventory were provided. The 1997 total inventory value was listed at either \$9,24,847 or \$7,824,005 and for 1998 at \$13,237,104 or \$12,660,524.

The vaccine inventory system also did not report accurate total yearly receipts and did not account for the distribution of vaccines. Printouts containing the amount of inventory received during the audit period, as requested by the auditors on two different days, were different. One total of inventory received was \$7,001,296 and another \$6,157,476. Immunization personnel reported that there were no records kept of the vaccine disbursed during the audit period.

The apparent causes of the inaccurate value and inventory counts of the vaccine inventory's were a lack of: 1) management oversight of the physical counts, 2) management oversight and control of the Vaccine Center by administrators of the Resource Management Branch, and 3) the lack of written policies and procedures governing the vaccine inventory process. We were told the Vaccine Center did not have a supervisor during all or part of our audit period.

This program has been a small program in the past, with few employees and minimum funding. It has only been since 1996 that the program has expanded with the addition of the Vaccine For Children program. With a small, stable staff working on a small, stable program, the necessity for written policies and procedures received a low priority.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Material Weaknesses Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-7: The Department Of Public Health Should Strengthen Controls Over The Vaccine Inventory System (Continued)

The quantities of specific vaccines maintained in inventory were used as the criteria to order additional stock. Incorrect inventory quantities could cause unnecessary vaccine orders or, for lower than expected levels, the inability to fill provider requests. Furthermore, the inventory system could not produce reliable balances for reporting the beginning and ending inventory, and the total vaccines received and disbursed during our audit period for the required note to the Schedule of Expenditures of Federal Awards.

Good internal control over all phases of the vaccine program, especially the inventory phase, must be maintained to ensure accurate ordering and maintenance of inventory levels. In addition, there are federal grant requirements for the maintenance of accurate recordkeeping.

Recommendation

We recommend the vaccine inventory be properly inventoried on a regular basis by Vaccine Center employees and that Immunization Program personnel supervise these inventories. A regular basis should be defined as the same time of each month until consistency is achieved between the physical counts and VACMAN. Once consistency is achieved, quarterly counts could be initiated, with an end of the year inventory count. APA should observe the year-end physical inventory. We also recommend the management of the Immunization Program compare the vaccine inventory levels maintained in VACMAN to regular physical inventory counts. This will assure management that the vaccine inventory computer system is reliable and accurate beginning and ending inventories and the total vaccines received and distributed during the fiscal year will be provided for reporting purposes. Furthermore, we recommend that the Resource Management Branch more closely manage the operations of the Vaccine Center, including on-site supervision and operational practices that will ensure accurate and timely inventory counts.

Management's Response and Corrective Action Plan

The Division of Resource Management, Procurement Branch hired a full-time, on-site supervisor for the Vaccine Center on March 1, 1999. A regularly scheduled physical inventory of the Vaccine Center is conducted every two weeks and the results are reconciled with VACMAN.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Material Weaknesses Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-7: The Department Of Public Health Should Strengthen Controls Over The Vaccine Inventory System (Continued)

Management's Response and Corrective Action Plan (Continued)

The Immunization Program began using VACMAN to order vaccines in January 1994, but the Program did not start using VACMAN to maintain a perpetual inventory until July 6, 1998. Prior to July 6, 1998, the inventory on hand balances on VACMAN included only vaccine shipments that had been received by the Vaccine Depot. The VACMAN inventory on hand did not reflect orders shipped from the Depot. On July 6, 1998 the Immunization Program began to maintain a perpetual inventory on VACMAN. Obviously the successful start up of a perpetual inventory system is dependent upon obtaining an accurate initial physical inventory. If this is done, as was the case in the beginning of the VACMAN perpetual inventory system, or if shipping errors are not discovered, discrepancies will continue to show up in the system until they are reconciled.

VACMAN is capable of producing numerous reports for the same time period dependent upon the parameters specified. For example, VACMAN can produce a report of inventory on hand including or excluding expired vaccines; including orders entered and not shipped or excluding orders entered and not shipped. Without seeing the reports and knowing the specific time period involved or the parameters of the report, the Immunization Program is not able to address the printouts referenced in IMM-3.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN

The Immunization Program has attempted to address this problem by:

- 1. Hiring a Coordinator for the Vaccine for Children (VFC) Program (Gary Bevill 1/1/99) who is responsible for implementing quality assurance activities, including vaccine accountability procedures identified in federal grant guidelines.*
- 2. Hiring a Supervisor (Glenn Lewis 3/1/99) who is responsible for overseeing the operations of the Vaccine Depot; taking physical inventories; and developing procedures to eliminate shipping errors.*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Material Weaknesses Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-7: The Department Of Public Health Should Strengthen Controls Over The Vaccine Inventory System (Continued)

Management's Response and Corrective Action Plan (Continued)

CORRECTIVE STEPS THAT HAVE BEEN TAKEN (Continued)

3. *Several corrective procedures have been initiated since January 1, 1999. They include:*
 - *Printing a daily VACMAN shipping order summary, including type of vaccine, lot numbers, and quantities of each vaccine to be shipped each day. Only the vaccines, lot numbers and the quantities listed on the daily shipping summary are pulled from the walk-in coolers and stocked in the daily picking refrigerator. Containers were purchases to separate individual provider's orders while they are being prepared for shipment to keep the orders from being mixed. If an order cannot be completely filled or if there are vaccines left in the picking refrigerator after all of the vaccine orders have been packaged and readied for shipment, then a shipping error has occurred and should be corrected before the orders go out. Mr. Lewis has developed a manual perpetual inventory procedure that is compared to the monthly physical inventory and the VACMAN inventory on hand report.*
 - *Developing a standard form to be used in taking a physical inventory.*
 - *Requiring that the Supervisor of the Vaccine Depot take a physical inventory each month. The physical inventory is compared to the VACMAN Inventory on Hand report and a Discrepancy Report is prepared by the VFC Coordinator. Attempts are made to resolve discrepancies by recounting stock and reviewing receiving reports. If a discrepancy cannot be resolved after two (2) consecutive physical inventories, then an adjustment is made to VACMAN.*
 - *Adjustments cannot be made to VACMAN until all efforts to resolve discrepancies have been made. Except for returned vaccines, adjustments cannot be made to VACMAN without the approval of Gary Bevill, VFC Coordinator, or Sandra Gambescia, Immunization Program Manager.*
 - *A Vaccine Depot Vaccine Return Form (see attached green form) has been developed which is to be filled out when vaccines are returned to the Vaccine Depot by a VFC provider. The form must be submitted to the Immunization Program. If vaccines reported of the Vaccine Return Form are returned to stock, the VACMAN inventory is adjusted accordingly by Lorraine Moore, VFC Program Procedures Development Specialist.*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Material Weaknesses Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-7: The Department Of Public Health Should Strengthen Controls Over The Vaccine Inventory System (Continued)

Management's Response and Corrective Action Plan (Continued)

CORRECTIVE STEPS THAT WILL BE TAKEN (Continued)

1. *Gary Bevill, VFC Coordinator will write a policies and procedures manual by October 1, 1999. The manual will include specific requirements related to physical inventories (must be taken on first and third Thursday of each month); reporting receipt of vaccines to inventory; unpacking and reporting returned vaccines making adjustments to VACMAN; and correcting shipping errors including follow-up with providers.*
2. *Out of state travel approval will be requested for Glenn Lewis, Vaccine Depot Supervisor, to visit another vaccine depot during the first quarter of FY 2000, to observe proper storage, handling, and shipping procedures. The site chosen will be one that is recommended by the Centers for Disease Control and Prevention.*

Other Matter Comments Relating To Internal Control And Compliance:

FINDING 98-CHS-8: The Department Of Public Health Should Improve Controls Over The Bank Reconciliation Process

The monthly bank reconciliations for the County Health Central Bank Account performed by the Division of Resource Management did not have evidence of independent management or supervisory review and were not initialed or dated as to the date they were prepared or the name or initials of the preparer.

Management did not have evidence that a timely bank reconciliation was done or of their review of the bank reconciliations for the County Health Central Bank Account. Internal controls over the safeguarding of assets relate to the prevention and timely detection of unauthorized transactions and unauthorized access to assets that could result in losses. Good internal control over all phases of the expenditure process must include the proper documentation and review by management of the monthly bank reconciliations.

Recommendation

We recommend that the preparer date and initial the monthly bank reconciliation on the date completed. We further recommend that management evidence the review of the monthly bank reconciliation by date and initial.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-8: The Department Of Public Health Should Improve Controls Over The Bank Reconciliation Process (Continued)

Management's Response and Corrective Action Plan

Since the audit was conducted, the performer of the reconciliation initials and dates the reconciliation and the manager of that branch also initials and dates.

FINDING 98-CHS-9: The Department Of Public Health Should Close Its County Health Central Bank Account

The Cabinet for Health Services maintains an unauthorized bank checking account that is used to process payments to local health departments.

There was no documentation that the approximately \$34 million in state checks issued to County Health Central Bank Account (CHCBA) annually was collateralized or that the overnight interest earned, approximately \$50,000 a month, was deposited into the State's main depository account.

Division of Resource Management employees stated that KRS 212.120 gives the Cabinet for Health Services the authority to have the bank account.

The Cabinet for Health Services utilizes a bank checking account to process payments to local health departments that is not authorized by the Finance and Administration Cabinet and KRS 41.070. The checks written on the CHCBA are not included in the state's accounting software system thereby preventing comprehensive state oversight.

In addition, the lack of collateralization of the CHCBA places the balance at risk and is in violation of KRS 41.240(1)(a).

Furthermore, the interest earned through a repurchase agreement's overnight sweep of the account is not deposited in the state's main depository account. The amount earned, approximately \$50 thousand a month, is an unknown and unbudgeted revenue source for certain programs.

KRS 41.070(1) Moneys to be deposited in state depositories – Exceptions – Designated depositories – Record of agencies states that:

Unless otherwise expressly provided by law, no receipts from any source of state money or money for which the state is responsible shall be held, used, or deposited in any personal or special bank account, temporary or otherwise, by any agent or employee of any budget unit, to meet expenditures or for any other purpose. All receipts of any character of any budget unit, all revenue collected for the state, and all public money and dues to the state shall be deposited in state depositories in the most prompt and cost-efficient manner available.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-9: The Department Of Public Health Should Close Its County Health Central Bank Account (Continued)

This statute and the accompanying cross-references and opinions of the Attorney General do not mention the Cabinet for Health Services and, therefore, the CHCBA is not exempted from the restrictions of this statute.

KRS 41.240(1)(a) Pledge of securities required of depositories – Qualifications for a reduced pledge – Eligible securities and other obligations states that:

Before any bank shall be named as a state depository to receive public funds, it shall either pledge or provide to the State Treasurer, as collateral, securities or other obligations having an aggregate current face value or current quoted market value at least equal to the deposits or provide to the State Treasurer a surety bond or surety bonds in favor of the State Treasurer in an amount at least equal to the deposits....

The foremost argument used by the Cabinet is that KRS 212.120, “Notice of establishment given Cabinet for Health Services – Allocation of state funds to districts – Equalization of allotments – Modification and cancellation of allotments – Appropriations not to lapse,” contains authorization for the allocation of state and federal administrative monies to local health departments and districts. Our reading of the statutes, KRS 212.120 and KRS 41.070, is that there is not support for the Cabinet for Health Services to maintain a bank checking account outside the state’s main checking account. These monies should flow through the state’s accounting system and the main state depository account.

Recommendation

We recommend the Cabinet for Health Services immediately close the County Health Central Bank Account and transfer the account balance to the state’s main depository account.

Management’s Response and Corrective Action Plan

The Cabinet for Health Services maintains an unauthorized bank checking account that is used to process payments to local health departments.

KRS 212.120 (4) “Nothing in this section shall be construed as requiring the Cabinet for Health Services to allot all funds available for local health purposes, or as prohibiting the department from allotting such portion thereof, as the department may determine, to a reserve account...”

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-9: The Department Of Public Health Should Close Its County Health Central Bank Account (Continued)

Management's Response and Corrective Action Plan (Continued):

The County Health Central Bank Account (CHCBA) is a clearing account for the disbursement of funds (i.e., grants and preventive Medicaid payments) to local health departments (LHDs). The Grants and Payments System operated by the Department for Public Health (DPH) is a general ledger accounting system that tracks all sources of funds to all LHDs. A LHD may receive a single check from the CHCBA that contains an amount of funding from every source of LHD grant funding contained in the budget of the DPH. The grants deposited in the CHCBA are appropriated by the General Assembly for LHDs. The Medicaid payments are payments to LHDs for the Preventive Medicaid Program. This Program is one provider, Kentucky Local Health Departments, rather than 55 separate entities. Medicaid issues one check for the statewide program based on the electronic billing from the Local Health Network software system and DPH distributes the payment to the appropriate LHD.

KRS 41.070 (1) "Unless otherwise expressly provided by law, no receipts..." KRS 12.120 is expressly provided by law.

"Receipts," defined in KRS 48.010 (15) includes "(a) "Nonrevenue receipts" means values accruing that either decrease an asset or create a liability. (b) "Operating receipts" means cash received by a budget unit for services rendered, or from the sale of materials, goods, or supplies created by the budget unit or of items held for resale. (c) "Revenue receipts" means values accruing as a result of taxation or revenues, or both, and without resultant increase in liabilities or decrease in assets, whether such values are represented by cash actually received or by amounts due and payable, or partly by each."

Grants for LHDs are appropriated by the General Assembly. Medicaid payments are earned by LHDs for services rendered. Attached is the Interagency Agreement for Preventive Health Services between the Department for Medicaid Services and the Department for Public Health to provide preventive health services to Medicaid recipients.

No documentation that funds are collateralized:

The Master Repurchase Agreement between the Cabinet and Farmers Bank and Capital Trust Company defines a group of securities of which DPH is the owner. The bank sends a copy of the daily confirmation of the account to the Kentucky State Treasurer's Office daily.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-9: The Department Of Public Health Should Close Its County Health Central Bank Account (Continued)

Management's Response and Corrective Action Plan (Continued):

Checks written on CHCBA are not included in the state's accounting software system, thereby preventing comprehensive state oversight.

Funds deposited in the CHCBA are a product of the state's accounting system. The grants for LHDs appropriated by the General Assembly are part of the budget for DPH. The transaction in the state's accounting software system is posted as grants to LHDs. Detailed records are maintained in DPH to document which LHD received which funds. Detailed records are maintained in LHDs as well. When the check is written from the State Treasury to the CHCBA, the funds are the property of LHDs and are administered by DPH.

No documentation that interest earned was deposited into the State's main depository account:

When the Department for Human Resources was created in 1973, the Kentucky Board of Health was brought under the Human Resources umbrella as the Bureau for Health Services. A separate bank account was maintained for LHDs and the interest was accrued to a separate bank account and used expressly for capital construction projects for LHDs and DPH. Funding in CHCBA is the property of LHDs and, therefore; the interest earned belongs to LHDs and not the main state depository account. The General Assembly appropriated interest from this bank account for each year of the FY 1987-1988 Biennium for an AIDS education program.

Recommend the Cabinet immediately close the CHCBA:

The County Health Central Bank Account is the single largest source of funding for LHDs. LHDs depend on the funding that flows through the CHCBA for their operating funds. Closing the account immediately would have disastrous consequences at this time.

The Cabinet will look into the validity of the CHCBA through the Finance and Administration Cabinet as authorization agent of bank accounts.

If validation is not substantiated, the DPH will work with the Cabinet for Health Services and the Finance and Administration Cabinet to develop procedures in combination with the DPH Grants and Payments System and the new Management Administrative and Reporting System (MARS) in order to have MARS issue the checks.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-10: The Department For Medicaid Services Should Improve Controls Over Nursing Facilities To Comply With Regulations

During the testing of internal controls and compliance of nursing facilities for meeting prescribed health and safety standards, we found that 7 out of 20 nursing facilities were not surveyed within 15 months of the previous survey. In addition, we found that the last survey date in the database that helps monitor these surveys did not agree for 5 out of 20 nursing facilities. This last finding was also noted in our last audit and included as a report comment.

Nursing Facilities could be ineligible because they are not surveyed and re-certified.

42 CFR 488.308 states that the survey agency must conduct a standard survey of each SNF and NF no later than 15 months after the last day of the previous standard survey.

Recommendation

We recommend that surveys be conducted within the 15 months so that each SNF and NF is re-certified and eligible.

Management's Response and Corrective Action Plan

The Office of Inspector General, Division of Licensing and Regulation (L&R), is responsible for licensing and certification of long-term care facilities. We are the recommending agency to Medicare/Medicaid offices. We are aware that for the year ended June 30, 1998, there were long-term care surveys which were not surveyed within 15 months of their previous survey. These concerns had already been identified by this office and guidelines were developed to remedy this situation. The remedies utilized are as follows: A tracking system to be maintained by each of our regional offices, development of specialized teams for long-term care in each region, and a database in this office to track dates and the number of months between surveys. Therefore, to date this office does not have any long-term care surveys that are over the 15-month time frame.

This office is mandated by HCFA to maintain and update the national database OSCAR, Online Survey Certification and Reporting System. The OSCAR system allows L&R to quickly access all of the data from surveys of health-related providers and suppliers in the Medicare and Medicaid program. This is the system that L&R utilize to assure compliance with the nine to 15 month requirements. HCFA has budgeted this office to conduct re-certification surveys of Medicare/Medicaid certified long-term care facilities within a nine to fifteen month timeframe. Therefore, this office has taken appropriate steps to ensure that certified long-term care facilities are surveyed within HCFA budgetary guidelines.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-10: The Department For Medicaid Services Should Improve Controls Over Nursing Facilities To Comply With Regulations (Continued)

Management's Response and Corrective Action Plan (Continued)

As of August 1992, time-limited agreements were eliminated for providers of nursing services for both Medicare and Medicaid. Medicare and Medicaid agreements for SNF's & NF's continue until termination action is completed and submitted to Medicaid Services. Therefore, the survey time frame would not effect eligibility for re-certification.

FINDING 98-CHS-11: The Hospital And Psychiatric Facilities Branch Should Monitor Length Of Stay In Hospitals And Psychiatric Hospitals In Accordance With Federal Regulations

During the review of lengths of stay (LOS) in Hospital and Psychiatric Hospital Branch, we found that the review for Hospital Branches had ceased in April of 1998. In addition, there was no review during the audit period for Psychiatric Hospital Branches. The no review of LOS in Psychiatric Hospitals is a repeat finding. A comment was made in FY 97 that this was not being performed.

During FY 98, the Hospital and Psychiatric Facilities Branch did not review recipients' LOS in mental hospitals and the review of LOS for hospitals ceased in April 1998. Although we were aware that the psychiatric cases had been excluded from the monitoring, we performed a cursory review of 10 recipients in order to establish if that exclusion was justifiable. Of the 10 that we examined, we found that 5 recipients scored in excess of 75 percentile per Psychiatric Length of Stay by Diagnosis for the Southern Region.

Our review of Hospital LOS consisted of 2 months randomly chosen and a sample of 10 was selected from each month. The two months selected had a registered Nurse (RN) reviewing the LOS. However, during the discussion with that RN, it was noted that they were pulled from this job duty in April 1998. It was their understanding that another RN would be assigned to perform this job duty. However, through further investigation and discussion, there is no one assigned to this duty at this time, nor is there someone assigned to review the LOS for psychiatric facilities.

Exclusion of the psychiatric population during the whole audit period and the exclusion of the hospital population for April, May, and June 1998 from the sample compromised the integrity of the review as a whole.

42 CFR 431.812 states that the state agency must review all cases to determine if the proper amount of recipient liability was computed. 42 CFR 431.814 does, however, allow for an approved sampling plan to be used. According to DMS's Utilization Control Monitoring Plan, in order to determine the propriety of claims, those with a LOS above the 75th percentile are to be reviewed.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-11: The Hospital And Psychiatric Facilities Branch Should Monitor Length Of Stay In Hospitals And Psychiatric Hospitals In Accordance With Federal Regulations (Continued)

Recommendation

We recommend that someone be appointed immediately to perform the review of lengths of stay for both Hospital and Psychiatric Facilities Branches and that this review begin as soon as possible.

Management's Response and Corrective Action Plan

The Department of Medicaid Services has recently transitioned into eight divisions. Monitoring of acute care hospital stays is no longer the responsibility of the Division of Long Term Care. This responsibility is assigned to Physical Health Operation and Field Services Branch for acute care hospitals and Division of Behavioral Health Programs for acute inpatient psychiatric services and free standing Psychiatric Hospitals. Marilyn Ferguson, RN is the coordinator for Behavioral Health Branch and Barbara Utter for Physical Health Operation and Field Services Branch.

In order to ensure proper review of length of stay for psychiatric and hospital branches, all nurses are attending an in-service in which training of data contained and use of the reports will be completed. The reports will be sorted in the future by either psychiatric or hospital patient. This is to facilitate the identification of type of patients for proper routing.

FINDING 98-CHS-12: The Department For Mental Health/Mental Retardation Services Should Strengthen Internal Controls And File Maintenance Procedures Within The SCL Waiver Program

Good internal controls provide for detailed policy and procedures guidelines for employees responsible for implementing the Supports for Community Living Waiver within the Department of Mental Health/Mental Retardation Services. Auditor was informed that a policy and procedures manual was in the "draft" stage and that none was available specific to the audit period July 1, 1997 through June 30, 1998. The *Supports for Community Living Manual* and the associated *Supports for Community Living Reimbursement Manual* are incorporated by reference in 907 KAR 1:145 which provides a descriptive template and legal nexus for implementation of the *SCL Manual*. Additionally, an Interagency Agreement between DMS and DMH/MRS segregates and further describes joint and individual duties of the two agencies. During our review of the AIS/MR and SCL Waiver recipients records we noted instances which may compromise the ability of DMH/MRS staff to effectively monitor persons enrolled in the SCL Waiver and/or determine eligibility, continued participation, and effective utilization of resources available under the Waiver.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-12: The Department For Mental Health/Mental Retardation Services Should Strengthen Internal Controls And File Maintenance Procedures Within The SCL Waiver Program (Continued)

Our findings are as follows:

- A. Our review revealed that recipient files related to AIS/MR activity prior to the implementation of the SCL Waiver (September 1, 1997) were prematurely archived.
- B. During our review of recipient files, we noted an instance of Level of Care Certification not being on file (Recipient #3234426[5]8).
- C. We reviewed 25 recipients of the SCL Waiver. Of the various services provided within the SCL Waiver, much of the covered service consisted of Community Habilitation Service (as described in Section V, Part B of the SCL Manual). The activities allowed under this provision of the SCL Waiver are not defined and verifiable by written policy and procedures at DMH/MRS. The terms described in the SCL Manual for covered Community Habilitation Service are those which are "provided based on goals which are therapeutic rather than diversional[sic] in nature." We noted no cases of questioned services related to the Community Habilitation Service. No further definition of the SCL Manual terms was available.
- D. Of our selection of 25 recipients, 5 were new to the SCL Waiver within the audit period July 1, 1997 through June 30, 1998. DMR/MRS staff was unable to produce records of initiation, coordination, financial ability, implementation and monitoring of the assessment and eligibility process application and waiting list placement documentation specific to the Support Coordinator Provider (SC) functions required for new recipient placement.

The effects of these findings are documented as follows.

- A. The process of retrieving the files was time consuming and unwieldy. Needed information was not readily available due to the files being located outside of the DMS and DMH/MRS offices. Without a comprehensive and historical repository of recipient records, DMH/MRS staff is unable to adequately assess and monitor incident reports and protect the health, safety, and welfare of people in the program and follow up with technical assistance to correct and improve personal support. Additionally, the APA is unable to access and verify information without considerable difficulty and delay.
- B. Level of Care Certification determinations are made by the contracted Peer Review Organization (PRO) and become part of the Recipient's permanent file. The certifications provide a verifiable determination of a recipient's needs and beginning and ending dates of coverage. Without this documentation, DMR/MRS cannot verify MMIS eligibility and service provider extension review. Additionally, the APA cannot verify key recipient data.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-12: The Department For Mental Health/Mental Retardation Services Should Strengthen Internal Controls And File Maintenance Procedures Within The SCL Waiver Program (Continued)

The effects of these findings are documented as follows: (Continued)

- C. Without concise definition of Community Habilitation Services in the *Supports for Community Living Manual*, and/or written policy and procedures available to DMH/MRS staff, there may be activities made available to SCL Waiver Recipients which are not in the best interest of maintaining their health, safety, and welfare. Additionally, costs may be diverted from activities better serve the person's needs and ensure that the services are "the best possible for that person" as described in the Interagency Agreement between DMH/MRS and DMS (MS97-98-6245 Section A, 10).
- D. Waiting lists (when applicable), placement allocations, and Support Coordinator records establish a verifiable basis for a person's entry into the SCL Waiver. Without these records, DMH/MRS cannot establish compliance with the *Supports for Community Living Manual* (Section VI). Additionally, the APA cannot determine compliance with placement requirements detailed in the Manual.

Medicaid funds that are paid to states by the federal government are considered federal awards expended and are covered under the Single Audit Act Amendments and OMB Circular A-133. DMH/MRS must establish and maintain internal controls designed to reasonably ensure compliance with federal laws, regulations, and program compliance requirements. Additional requirements regarding roles and responsibilities of DMH/MRS are discussed in 907 KAR 1:145, and the *Supports for Community Living Manual* incorporated therein, the associated *Supports for Community Living Payment Rate Determination Manual*, and the *Interagency Agreement between the Department for Medicaid Services and the Department for Mental Health/Mental Retardation Services*. A good internal control structure and well-defined policy and procedures are essential for the achievement of full accountability and compliance with applicable laws and regulations. Additionally, timely access to records is crucial to an audit and DMH/MRS.

Recommendation

We recommend the DMH/MR create and implement an effective policy and procedures manual and better define the Community Habilitation Service. Additionally, DMH/MRS should refrain from archiving files until audited by the APA, and/or three years time has passed.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-12: The Department For Mental Health/Mental Retardation Services Should Strengthen Internal Controls And File Maintenance Procedures Within The SCL Waiver Program (Continued)

Management's Response and Corrective Action Plan

- A. *In the future, recipient files will be archived only after audit and/or until after three years have passed.*
- B. *We agree with the audit finding that a Level of Care Certification must be on file for every plan that is approved and believe that the location of the form for the APA was a transition problem between AIS and SCL that should not reoccur. This Level of Care Certification for the referenced Recipient #323442658 was for an AIS plan that began 8/4/97 to 2/6/98, which was before the inception of the SCL. This LOC should have been in the Medicaid individual recipient file.*

Due to renovations to the building and reorganization, DMS has been required to physically move several times during the last twelve months. Therefore, it is possible that some documents may have been misfiled. DMS will continue to search for historical files.

- C. *Community Habilitation Services are defined on pages 5.2 and 5.3 of the SCL Manual and reflects the definition of the service as provided on page B12a of the waiver as approved by HCFA (attached).*

The definition of the service includes commonly accepted and understandable terms for professionals in the field of mental retardation. To more narrowly define or include additional restrictions to the services would defeat the goals of providing individually determined services which meet the person's needs and would result in a program that is much more prescriptive than the federal mandate. When DMS and DMH/MRS, with the involvement of recipients and advocates, developed this definition and ultimately received approval from HCFA, it was our intention to allow for more flexibility in meeting the individual's day program needs utilizing the resources of the community. It is not our desire or our intent to allow activities which do not fall within the established service definition or would compromise the health, safety, or welfare of individuals served. In addition, Area Administrators visit each Community Habilitation Program during certification reviews and make additional visits throughout the year to monitor and assist the provider in program implementation.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-12: The Department For Mental Health/Mental Retardation Services Should Strengthen Internal Controls And File Maintenance Procedures Within The SCL Waiver Program (Continued)

Management's Response and Corrective Action Plan (Continued)

- D. Individual records which contain the service initiation, coordination, financial ability, implementation, and assessments are maintained at the Support Coordination Provider site, not by the DMH/MRS. This information is reviewed by DMH/MRS staff for compliance during the certification process at least annually.*

The Support Coordination Provider is required to submit an application packet to the Area Administrator as described in the SCL Manual, Transmittal #2, page 6.6 prior to approval for services.

During a part of the audit period "placement documentation" was maintained in the regional offices. It is now kept in the DMH/MRS central office.

The SCL waiting list is maintained in the Central Office. The DMH/MRS have all of the required documents and information for placement on the waiting list. DMH/MRS is unclear as to whom the APA directed the request for information.

- E. An SCL Manual has always governed the SCL Program and has included a definition of Community Habilitation Services, as described in the waiver that was approved by HCFA. SCL files will not be archived until they are audited or three years have passed.*

Auditor's Response

With respect to DMH/MRS Management Response "C" concerning the Community Habilitation Services functions of the SCL Waiver, we do not recognize the language of the SCL Manual as definitive enough to provide service parameters that ensure protection of the best interests of the persons serviced by the Waiver. We recommend that the DMH/MRS define, by exception, those activities that are "diversional" rather than therapeutic. Given the autonomy of SCL Waiver providers, and the sometimes limited training and competency levels of caregivers employed by the providers, circumstances exist that could allow unbridled Community Habilitation activity selection. If the definition of the Community Habilitation Service contains, as DMH/MRS contends, "commonly accepted and understandable terms for professionals in the field of mental retardation," then defining unallowable Community Habilitation Services should not imperil the flexibility of the Waiver. Without express definitions of these terms, taxpayers cannot be ensured that funds and resources available under the SCL Waiver are being best used. As it stands, the established service definition is vague and open to wide variation of interpretation by providers and individuals employed as caregivers by the providers.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-12: The Department For Mental Health/Mental Retardation Services Should Strengthen Internal Controls And File Maintenance Procedures Within The SCL Waiver Program (Continued)

Auditor's Response (Continued)

With respect to DMH/MRS Management Response "D" comments concerning the availability of service initiation, and other records maintained at the Support Coordination Provider site(s), we request that DMH/MRS document the review process in an internal policy and procedures manual, along with other internal operating guidelines not contained in the SCL Manual. Internal reviews of this material were either not documented or made available to the APA during the audit.

FINDING 98-CHS-13: The Department For Medicaid Services Should Strengthen Controls Over The Supports For Community Living Waiver

Good internal controls provide for detailed policy and procedures guidelines for employees responsible for implementing the Supports for Community Living Waiver within the Department for Medicaid Services. The *Supports for Community Living Manual* and the associated *Supports for Community Living Reimbursement Manual* are incorporated by reference in 907 KAR 1:145 which provides a descriptive template and legal nexus for implementation of the *SCL Manual*. Additionally, an Interagency Agreement between DMS and DMH/MRS segregates and further describes joint and individual duties of the two agencies. During our review of the AIS/MR and SCL Waiver Provider records, we noted instances which may compromise the ability of DMS staff to effectively monitor services provided to persons enrolled in the SCL Waiver and/or determine eligibility, continued participation, and effective utilization of resources available under the Waiver. Our findings follow:

- A. During the audit period, the Peer Review Organization (PRO/The Council) was responsible for conducting surveys and Incident Report reviews of the 56 providers of the AIS/MR - SCL Waiver. Plans of Correction were due within 30 days after notice by DMS and were maintained in provider notebooks along with surveys and Incident Reports. We noted one case where no POC was on file (Provider #33700451); one case where a POC was not received within the annual survey cycle (Provider #33900143); one case where there was no evidence of acceptance of the POC in the provider notebook (Provider #33900184); one case where the POC was not received at DMS until 160 days after the due date (Provider #33900655); and one case where there was no follow-up to an Incident Report of high importance (Provider #33900663). The concerns with POC documentation are a repeat of last year's audit findings.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-13: The Department For Medicaid Services Should Strengthen Controls Over The Supports For Community Living Waiver (Continued)

- B. The basis for our examination of AIS/MR - SCL Waiver Providers was an Ad Hoc Request (#090) facilitated by the Unisys reporting system. This Ad Hoc was alleged to represent all AIS/MR -SCL providers certified and billing within the audit period. We compared the provider ending eligibility dates on the Ad Hoc Report to the PRO certification end dates listed in the provider notebooks and/or provider enrollment folders. We noted seven cases (Provider #s 33700360, 33900135, 33900192, 33900309, 33900440, 33900598, and 33900721) where the Unisys Report dates did not agree with the PRO survey letter dates. One provider (#33300435) lacked documentation in the provider notebook and/or provider enrollment files enabling us to verify the end date. Additionally, we identified one provider (# 3300732) that was certified and billed within the audit period July 1, 1997 through June 30, 1998 and not listed on the Unisys Report. The end date concerns are a repeat of last year's audit findings. POC letter response dates were sometimes entered as end dates in the MMIS system – this practice did not seem to be consistent.

The effects of these findings are documented as follows.

- A. The DMS was responsible for monitoring PRO Surveys, Plans of Correction, and Incident Report completion as part of its duty to ensure provider compliance with the *Supports for Community Living Manual*. The Plans of Correction are an effective way for DMS to ensure provider compliance by initiating appropriate sanctions and improving provider performance and facilitating the health, safety, and welfare requirements of persons enrolled in the waiver. Without a stable and effective means of monitoring and enforcing provider compliance, the DMS can potentially imperil the well being of persons enrolled in the waiver and a provider could be paid without complying with its legal requirements. Additionally, with respect to the Incident Reports, it is crucial that DMS maintain full documentation so that it can assure that the waiver service program is operated in compliance with all applicable state and federal laws.
- B. The certification end dates need to be constantly applied and verifiable in order for the MMIS billing system to work. If DMS chooses to utilize POC response dates as end dates, it should adopt consistent documented policy and procedures. The DMS does not keep historical documentation in the form of Ad Hoc (MMIS) generated end dates; therefore, the APA verifies post-audit MMIS end dates in order assess end date utilization during the audit period. Without historical Ad Hoc Reports and/or an archived database, the APA is unable to completely review and verify the MMIS end date input system.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-13: The Department For Medicaid Services Should Strengthen Controls Over The Supports For Community Living Waiver (Continued)

Medicaid funds that are paid to states by the federal government are considered federal awards expended and are covered under the Single Audit Act Amendments and OMB Circular A-133. DMS must establish and maintain internal controls designed to reasonably ensure compliance with federal laws, regulations, and program compliance requirements. Additional requirements regarding roles and responsibilities of DMS are discussed in 907 KAR 1:145, and the *Supports for Community Living Manual* incorporated therein, the associated *Supports for Community Living Payment Rate Determination Manual*, and the *Interagency Agreement between the Department for Medicaid Services and the Department for Mental Health/Mental Retardation Services*. A good internal control structure and well-defined policy and procedures are essential for the achievement of full accountability and compliance with applicable laws and regulations. Complete and verifiable records are required in or to fulfill DMS's legal requirements.

Recommendation

We recommend DMS implement an effective policy and procedures manual. DMS should maintain complete provider notebooks and include a log of survey dates, POC dates, certification end dates and complete Incident Reports including DSS correspondence. We recommend a periodic/monthly run of Ad Hoc report end dates for all SCL Waiver providers so that the APA can completely verify the MMIS system. We recommend that the DMS adopt a consistent policy regarding POC letter due date MMIS system input.

Management's Response and Corrective Action Plan

A. *The Peer Review Organization (PRO) was responsible for the level of care determination only. The Council, which is not the same organization, was responsible for conducting surveys and certification and Incident Report reviews for the Supports for Community Living (SCL) Providers.*

(1) *The POC for provider #33700451 is located at the Department for Mental Health and Mental Retardation (DMH/MR). The approval/denial for this POC was during the transition of the certification reviews from The Council to the DMH/MR.*

(2) *We are unable to determine your issue that for provider #33900143 the POC was not received within the annual survey cycle. The documentation attached will indicate the trail of extension and follow-up on-site reviews performed.*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-13: The Department For Medicaid Services Should Strengthen Controls Over The Supports For Community Living Waiver (Continued)

Management's Response and Corrective Action Plan (Continued)

- (3) *We concur that the POC for provider #33900184 could not be found. It should be noted that the Department for Medicaid Services has undergone several physical relocations as a result of a remodeling project in the building and reorganization during the last twelve months. Understandably, then, with the physical activities in moving and the changes in personnel, some records may be misfiled. We shall make every effort to ensure that our filing systems improve.*
 - (4) *We concur that the POC for provider #33900655 could not be found. It should be noted that the Department for Medicaid Services has undergone several physical relocations as a result of a remodeling project in the building and reorganization during the last twelve months. Understandably, then, with the physical activities in moving and the changes in personnel, some records may be misfiled. We shall make every effort to ensure that our filing systems improve. However, as the attached documentation indicates, (per fax confirmation sheet) the POC was received by The Council on April 21, 1998, which was within the allotted time frame. The letters sent to providers require that the POC be sent to the Council within 30 days and the provider met this requirement.*
 - (5) *This incident was referred to Adult Protective Services (as required) for investigation.*
- B. The PRO is responsible for LOCs only. We concur that there are discrepancies between the end dates listed in the provider notebooks and the end dates loaded in the MMIS system. Instead of entering the certified period in the MMIS system, staff was only entering the thirty (30) days contingent upon the receipt of a POC. This practice has been discontinued. The Ad Hoc Request (#090) which was provided by Unisys is only as accurate as the request made. The MMIS system is very precise and any request made must be just as precise. Attached you will find a MMIS screen print-out for Provider #33300732 that indicates the enrollment status of this provider.*

The Department for Medicaid Services (DMS) has an effective policy and procedures manual to cover the period of this audit. Under contract, the DMH/MR is now responsible for maintaining the provider information, including survey dates, POC dates, certification end dates and complete Incident Reports. DMS does not require that a monthly Ad Hoc report be run, as this would be repetitive work for the staff involved in the provider end dates.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-13: The Department For Medicaid Services Should Strengthen Controls Over The Supports For Community Living Waiver (Continued)

Auditor's Response

With respect to Management's Comments (Item #A-2) regarding POC receipt within the annual survey cycle, we based our findings on the Council's April 8, 1998 letter to DMS which is included in our workpapers and among the documents forwarded with the DMS response. The letter states, in pertinent part that "the plan of correction that was submitted is irrelevant due to the fact that is[it] was so late and another review was already conducted March 23 - 25, 1998." Without expedient follow-ups to Plans of Correction, DMS cannot be assured of provider implementation. Evidence submitted with DMS's response to this issue indicates that the provider's POC may have been mailed to another office in error. This being the case, we acknowledge reasons for the delay.

With respect to Management's Comments (Item #A-5) concerning evidence of follow-up to a major incident, we do not dispute that Adult Protective Services was not notified; however, evidence of the notification was not in the provider notebooks maintained by DMS.

With respect to Management Comments (Item B), the APA does not acknowledge any policy and procedures guidelines, other than the SCL Manual, as being made available for audit. Although the SCL Manual has been accepted by HCFA, and codified into law, it does not provide a detailed description of the internal policies and procedures necessary for DMS employees to effectively implement and oversee the waiver.

FINDING 98-CHS-14: The Department For Medicaid Services Should Strengthen Controls Over The Home And Community Based Waiver

Good internal controls provide for detailed policy and procedures guidelines for employees responsible for implementing the Home and Community Based Waiver Services within the Department for Medicaid Services. The auditor was presented with a detailed policy and procedures manual; however, this manual was not contemporaneous with the audit period July 1, 1997 through June 30, 1998. The *Home and Community Based Waiver - Adult Day Health Manual* and the associated *Reimbursement Manual* are incorporated by reference in 907 KAR 1:160 which provides a descriptive template and legal nexus for implementation of the Manual. During our review of the HCB Waiver Provider on-site review records, we noted instances which may compromise the ability of DMS staff to effectively monitor services provided to persons enrolled in the HCB waiver and/or determine eligibility, continued participation, and effective utilization of resources available under the waiver. Our findings follow:

- A. On-site reviews were documented on an on-site review list provided to the auditor by the Long-Term Care staff. One review could not be located by the auditor or responsible personnel within DMS (Provider #42001040).

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-14: The Department For Medicaid Services Should Strengthen Controls Over The Home And Community Based Waiver (Continued)

- B. Current HCB Waiver Policy requires that two or three HCB recipients be visited and interviewed as part of the review process. Auditor was not provided with a policy and procedures manual or guidelines contemporaneous to the audit period; however, we feel that two or three visits per provider is a reasonable level of examination. No recipients were visited during the on-site review of Provider #42017566. One recipient was visited for Provider #42001172. One recipient was visited for Provider #42540039 and the visit was not documented in the worksheet file. Of the recipients visited for Provider #42001974, recipient #405607580 was not documented on the HCB Review Form.
- C. We were unable to confirm the recipient visits for Provider numbers 42002907, 42002378, 42030080, and 42005348 due to the lack of availability of nurse worksheet files.
- D. Follow-up surveys were not performed for any of the Plans of Correction during the audit period.
- E. Provider #42540039 had a recoupment issue indicated on the HCBW Review Form and there was no evidence in the on-site review file that the funds were collected by DMS and/or the issue finalized. Provider #42005348 had a recoupment issue noted in the on-site review form and no documentation of payment and/or finality in the file. Provider #42002816 had a recoupment issue and request for payment with no evidence of the payment in the file.
- F. Plans of Correction were not located in Provider Files for #42001974 and #42002816.

The effects of these findings are documented as follows:

- A. Without secure on-site review file storage, DMS cannot ensure that a provider's legal obligations are fulfilled and that Plans of Correction and reimbursement issues are met.
- B. DMS (or the current contracted party) should ensure that a reasonable number of recipients are visited and that the visits are fully documented.
- C. The nurse worksheet files provide detailed backup for reimbursement issues, patient visits, and other details not provided in the on-site review files. DMS should ensure these files are secure and filed in duplicate.
- D. Follow-up surveys ensure that on-site review recommendations are implemented and that the health, safety, and welfare issues of HCBW recipients are being looked after. Additionally, follow-up surveys provide a basis for verification of any recoupment issues brought-up during the review. Without following up on recommendations, DMS can only rely on prospective statements of compliance made by providers.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-14: The Department For Medicaid Services Should Strengthen Controls Over The Home And Community Based Waiver (Continued)

E. These recoupment issues should be reviewed to ensure that money is not owed.

F. The Plans of Correction should be located and any pending issues addressed.

Medicaid funds that are paid to states by the federal government are considered federal awards expended and are covered under the Single Audit Act Amendments and OMB Circular A-133. DMS must establish and maintain internal controls designed to reasonably ensure compliance with federal laws, regulations, and program compliance requirements. Additional requirements regarding roles and responsibilities of DMS are discussed in 907 KAR 1:160, and the *Home and Community Based Waiver - Adult Day Health Manual* incorporated therein and the associated *Home and Community Based Waiver Reimbursement Manual*. A good internal control structure and well-defined policy and procedures are essential for the achievement of full accountability and compliance with applicable laws and regulations. Complete and verifiable records are required in or to fulfill DMS's legal requirements.

Recommendation

We recommend DMS continue with their current efforts in implementing an effective policy and procedures manual. If DMS cannot locate the missing on-site review folder, they should investigate the reason(s) why the review was requested and see to it that a review is conducted by the current entity responsible for the on-site reviews. Further, DMS staff should take measures to ensure that reviews are safely stored in secure environments and filed in more than one place. Any incomplete documentation should be located if possible and recoupment issues should be fully investigated to ensure that no money is owed. DMS should implement a policy (or enforce any applicable current policy) to ensure that Plans of Correction can be tested through further field investigation and/or desk audits.

Management's Response and Corrective Action Plan

A. *We concur that one review could not be found. It should be noted that the Department for Medicaid Services has undergone several physical relocations as a result of a remodeling project in the building and reorganization during the last twelve months. Understandably, then, with the physical activities in moving and the changes in personnel, some records may be misfiled. We shall make every effort to ensure that our filing systems improve.*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-14: The Department For Medicaid Services Should Strengthen Controls Over The Home And Community Based Waiver (Continued)

Management's Response and Corrective Action Plan (Continued)

- B. *There is no requirement under the HCB waiver, as approved by HCFA, to perform on-site reviews. However, as time permits, it is our practice to do so as a means of voluntary internal accountability. The HCB Program has always had a reimbursement manual and a services manual that are incorporated by reference into 907KAR 1:170 and 1:160, respectively. Manuals with an effective date of 3/97 were provided to the auditor. (See attached).*

*As previously stated, there is **not** an on-site review requirement in the waiver, as approved by HCFA. The HCB Review Form is an internal form and is not required by the waiver as approved by HCFA.*

In regard to the remainder of the comments relating to the review of the recipients and providers, we concur with the exception of Provider #42001974. In this case, recipient #405607580 was included on the client list and had an individual Home Review sheet. (See attached).

- C. *We concur with all the comments except for Provider #42002378, which had an on-site review on 2/18/98. We noted that a date of 2/28/97 was in-put into a worksheet in error. However, all other documentation clearly indicates a date of 2-18-98 (See attached).*
- D. *Follow-up surveys, i.e. (on-site reviews) are not required by the HCB Waiver as approved by HCFA.*
- E. *Provider #42540039 and Provider #42002816 recoupment issues regarding collection and verification of payment to the Department for Medicaid Services is a function of the Division of Financial Systems, Financial Management Branch. Provider #42005348 no longer has a recoupment issue as evidenced in the attachments.*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-14: The Department For Medicaid Services Should Strengthen Controls Over The Home And Community Based Waiver (Continued)

Management's Response and Corrective Action Plan (Continued)

- F. If, as a result of our on-site review, we find non-compliance, we may ask for a POC. However, a POC may not be required. Plans of Correction (POC's) were not located in Provider Files for #42001974. A Plan of Correction was located for Provider #42002816. (attached).*

We agree that your recommendations regarding increased on-site reviews and follow-up surveys, if enacted, would prove to be of benefit to the program. However, throughout the body of our responses, we have pointed out the requirements of the Waiver in this instance. It is our practice to perform on-site reviews and follow-ups as a means for internal monitoring and control. Therefore, because the PRO has nursing staff located throughout the state, they have assumed the on-site review functions for the DMS, including any indicated follow-up reviews.

Auditor's Response

With respect to Management's Comment "B" findings, we acknowledge that there is no express requirement within the HCB Manual, or otherwise within the law, that DMS perform on-site reviews of HCBW providers or recipients. Nevertheless, DMS has exercised due prudence in acknowledging the need for such reviews and performing (if not adequately documenting) them throughout the audit period. Although HCFA does not require the reviews, we believe that they are needed and, as such, should be structured in such a way that a representative sample is selected for review. Additionally, the reviews should be fully documented and recipient visits should include narrative accounts of the person's satisfaction, or lack thereof, with the service. We do not concur that "internal accountability" is voluntary; rather, it is a requisite part of DMS's duty and ultimate responsibility for ensuring recipients of HCBW services are receiving good care. Since the on-site reviews are not covered in the HCB Waiver Manual, internal policy and procedure documentation is the best way to ensure DMS's duties to the recipients are fulfilled and taxpayers' interests are protected.

With respect to Management's Comment D regarding that HCFA does not require follow-up surveys, we do not see the lack of express legal requirement as an inhibiting factor. Without follow-up to the provider's prospective statements of compliance, there is little, if any, assurance that the provider will follow through with its Plan(s) of Correction. We also note that DMS's current policy and procedures notebook contains documentation that "a follow up visit will be performed within 6 months."

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-14: The Department For Medicaid Services Should Strengthen Controls Over The Home And Community Based Waiver (Continued)

Auditor's Response (Continued)

With respect to Management's Comment E that recoupment issues/claims are a function of the Division of Financial Systems, we note that the two providers cited were among several that had recoupment issues. For these two providers there was no evidence of finality in the DMS files. Other Provider files with similar issues contained evidence that recoupment issues were finalized. DMS is responsible for oversight of the waiver and it is important that full documentation be provided in the on-site review files and that DMS ensure that no monies are owed.

With respect to Management's Comment F that Plans of Correction are not required for all reviews, we acknowledge this; however, a POC for the provider in question was noted as being requested by DMS – none was in the on-site review file.

FINDING 98-CHS-15: The Department For Medicaid Services Should Improve Record Keeping And Monitoring Of HCFA- 1539 Form Certifications

Good internal controls provide for detailed policy and procedures guidelines for employees responsible for implementing the Home and Community Based Waiver Services within the Department for Medicaid Services. Auditor was presented with a detailed policy and procedures manual; however, this manual was not contemporaneous with the audit period July 7, 1997 through June 30, 1998. The *Home and Community Based Waiver - Adult Day Health Manual* and the associated *Reimbursement Manual* are incorporated by reference in 907 KAR 1:160 which provides a descriptive template and legal nexus for implementation of the Manual. During our review of the HCB Waiver Provider enrollment and certification records, we noted instances which may compromise the ability of DMS staff to effectively monitor services provided to persons enrolled in the HCB Waiver and/or determine eligibility, continued participation, and effective utilization of resources available under the Waiver.

Our findings follow:

- A. During our testing of HCB Waiver Provider Enrollment and Provider Certification we noted that Survey cycle information was not included in sufficient detail on the face of the HCFA-1539 C & T forms. A DMS internal memorandum, dated February 23, 1998 suggests that survey cycle information be denoted on the HCFA-1539 form. Surveys conducted on Providers #42001768 (April 1, 1998), #42003590 (June 19, 1998), #42015560 (May 29, 1998) were of those selected from a larger sample encompassing the audit period July 7, 1997 through June 30, 1998. These three Providers, surveyed after the memorandum, did not have survey cycle information noted on the HCFA-1539 forms.
- B. One of the providers selected in our sample was located out-of-state and no HCFA-1539 form was included in the Provider Enrollment file.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-15: The Department For Medicaid Services Should Improve Record Keeping And Monitoring Of HCFA- 1539 Form Certifications (Continued)

The effects of these findings are documented as follows:

- Without survey cycle information for HCBW providers denoted on the face of the HCFA-1539, DMS Provider Enrollment staff cannot readily verify survey obligations. Providing the information on the form will provide a comprehensive/historical record of survey cycle obligations.
- Home-state HCFA-1539 or similar detailed information provides written and verifiable record of survey and certification compliance.

Medicaid funds that are paid to states by the federal government are considered federal awards expended and are covered under the Single Audit Act Amendments and OMB Circular A-133. DMS must establish and maintain internal controls designed to reasonably ensure compliance with federal laws, regulations, and program compliance requirements. Additional requirements regarding roles and responsibilities of DMS are discussed in 907 KAR 1:160, and the *Home and Community Based Waiver - Adult Day Health Manual* incorporated therein and the associated *Home and Community Based Waiver Reimbursement Manual*. A good internal control structure and well-defined policy and procedures are essential for the achievement of full accountability and compliance with applicable laws and regulations. Complete and verifiable records are required in order to fulfill DMS's legal requirements.

Recommendation

We recommend DMS comply with its policy decision and include survey cycle dates on the face of the HCFA-1539 form. We recommend that out-of-state provider files include home state C&T information if practicable.

Management's Response and Corrective Action Plan

- A. *Out-of-state Providers who provide services to recipients in Kentucky are not surveyed for certification by the Division of Licensing and Regulation. They are, however, surveyed for licensing purposes. Copies of the survey for licensure and the agency license are included in the agency's Provider Enrollment file.*
- B. *Survey cycle information is placed on the HCFA-1539 by the Division of Licensing and Regulation in the Office of the Inspector General. DMS staff will work with appropriate staff in the Division of Licensing and Regulation to resolve this issue.*
- C. *DMS staff are reviewing options for obtaining home-state documentation for out-of-state providers to verify survey and certification compliance.*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-16: The Department For Medicaid Services Should Strengthen Controls Over Monitoring The Home And Community Based Waiver

Good internal controls provide for detailed policy and procedures guidelines for employees responsible for implementing Home and Community Based Waiver Services recipient monitoring within the Department for Medicaid Services. We were presented with a policy and procedures manual; however, this manual was not contemporaneous with the audit period July 1, 1997 through June 30, 1998. The *Home and Community Based Waiver - Adult Day Health Manual* and the associated *Reimbursement Manual* are incorporated by reference in 907 KAR 1:160 which provides a descriptive template and legal nexus for implementation of the Manual. During our review of the HCB Waiver Recipient records, we noted instances which may compromise the ability of DMS staff to effectively monitor services provided to persons enrolled in the HCB Waiver and/or determine eligibility, continued participation, and effective utilization of resources available under the Waiver. We also noted possible problems with the DMS contract for HCBW recipient imaging/data retrieval services entered into with Unisys Corporation by the August 1994 RFP, PCT #BP006077. Our findings follow:

- A. The HCB Waiver Manual does not appear to contain detailed provisions for DMS oversight and evaluation of HCBW recipients; however, the Manual specifies that an Assessment Form (MAP-351), physician's recommendation, Kentucky Medicaid Certification Form (MAP-350), Prior Authorization Form (MAP-9), PRO Certification, and physician's statement of NF need/HCB Waiver request be submitted to DMS for each recipient. Within the DMS, we could locate none of these records related to HCBW recipients. DMS solicited the requisite recipient documents from the various HCBW Providers. Of the 39 recipients selected for DMS testing, recipient data was not available for the following:

Recipient Number	Provider Number	Ad Hoc #089 Sequence
718032268	4200119800	10
406021495	4200192500	31
405405235	4200307900	73
431502552	4200501700	98
401347843	4201001700	115
403825304	4201004100	140
317289328	4201256700	165
407363549	4205114400	190
402725337	4262002100	198

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-16: The Department For Medicaid Services Should Strengthen Controls Over Monitoring The Home And Community Based Waiver (Continued)

With the exception of Ad Hoc item #73, all recipients indicated activity within the audit period July 1, 1997 through June 30, 1998 as evidenced by beginning and ending dates of eligibility on the Ad Hoc Request – our request was for recipients with paid claims during the period. Ad Hoc item #73 listed beginning eligibility as September 10, 1998 and ending eligibility of March 9, 1999; however, we found evidence of certification (PRO level-of-care) throughout the entire audit period was located in the Unisys database.

- B. We requested Assessment/Reassessment Packages (MAP-350), approval letters, MAP-9 and MAP-10 documentation, level-of-care determinations, modification documentation/physician's orders for our sample of 39 HCBW recipients. Of our requested sample, for which information was obtained by DMS from the HCBW providers, some recipient files either lacked the requested supporting documentation or contained incomplete information on the face of the forms. These are as follows:

Recipient Number	Provider Number	Ad Hoc #089 Sequence
311365656	4200181800	23
405078227	4200247700	56
402304997	4200287300	65
404605813	4200356600	80
407109584	4200630400	105
401304773	4201002500	123
400022390	4201011600	148
405490875	4201456300	173
403171182	4200104000	2
403344955	4200109900	3
275221448	4200110700	4
403456426	4200125500	11
269221689	4200126300	12
401648751	4200126300	13
405052064	4200126300	14

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-16: The Department For Medicaid Services Should Strengthen Controls Over Monitoring The Home And Community Based Waiver (Continued)

- C. Auditor was informed by DMS of the Unisys scanned image database system for HCBW recipients. Unisys scanned HCBW recipient data as part of its Medicaid contract. Within the audit period July 1, 1997 through June 30, 1998, the information was input into the system for an indeterminate period of time. The scanned data was input into an online system, ostensibly for DMS staff retrieval and use. We could not gain access to the system through the DMS staff member recommended by the DMS Long-Term Care Director. According to DMS staff and the Unisys Claims Operations Manager, recipient data is not available by MAID#, HCBW#, and/or HCBW recipient name. The system can only be utilized by inputting recipient service date(s). Storage platters must be manual fed into the database at Unisys for any historical inquiry. The auditor obtained a copy of the August 1994 RFP related to the Unisys contract. The RFP states, in what appears to be pertinent part, that on-line inquiry and update screens should accommodate recipient service data with access by recipient ID and provider ID and current and historical data (Section 4.3.5.3.2).

The effects of these findings are noted as follows.

- A. DMS does not maintain HCBW recipient files and/or ready access to recipient data maintained by HCBW Providers. It appears to perform virtually no monitoring of recipient assessment/reassessment data, modifications, and documentation related to enrollment and service of HCBW recipients. Without a process to verify and monitor clinical records, and comprehensive plans of care, it is not possible for the DMS to fully evaluate the effectiveness of the waiver. Additionally, without accurate MMIS beginning and ending eligibility dates, there is no readily available system to retrieve aggregate HCBW participation records.
- B. If HCBW recipient records maintained by providers are incomplete and/or missing, the health, safety and welfare of recipients may be imperiled.
- C. DMS may have expended funds for a data retrieval system that is not functional. The lack of a readily accessible database could seriously jeopardize DMS's ability to monitor and review recipient utilization patterns to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-16: The Department For Medicaid Services Should Strengthen Controls Over Monitoring The Home And Community Based Waiver (Continued)

Medicaid funds that are paid to states by the federal government are considered federal awards expended and are covered under the Single Audit Act Amendments and OMB Circular A-133. DMS must establish and maintain internal controls designed to reasonably ensure compliance with federal laws, regulations, and program compliance requirements. Additional requirements regarding roles and responsibilities of DMS are discussed in 907 KAR 1:160, and the *Home and Community Based Waiver - Adult Day Health Manual* incorporated therein and the associated *Home and Community Based Waiver Reimbursement Manual*. A good internal control structure and well-defined policy and procedures are essential for the achievement of full accountability and compliance with applicable laws and regulations. Complete and verifiable records are required in or to fulfill DMS's legal requirements. The Unisys RFP (PCT#BP006077) appears to require recipient data search by name and number.

Recommendation

We recommend DMS implement a system that will provide ready access to HCBW recipient assessment/reassessment records and related documentation. We recommend that DMS further investigate the validity of HCBW MMIS eligibility data to ensure that it is complete and accurate and take corrective steps if errors are present. We recommend that DMS monitor HCBW recipient records to ensure completeness, accuracy and compliance with applicable laws and regulations. We recommend that DMS investigate compliance with the Unisys contract provisions and take steps to recover damages if warranted and practicable. We recommend that DMS continue with its current development of and HCBW operations policy and procedures manual.

Management's Response and Corrective Action Plan

- A. *It is not the department's intent to specify detailed internal oversight and evaluation procedures in the HCB Policy Manual. It is imperative that the department retains maximum flexibility to ensure that emerging issues that require immediate oversight are addressed in the most effective and efficient means possible at any point in time. Further, the HCB Waiver does not require that the policy manual contain detailed internal oversight and evaluation procedures.*

In regard to the APA's inability to obtain HCB recipient files from providers or DMS, it should be noted that during the audit period, Unisys stopped imaging these files and forwarded all remaining files to DMS. Also, DMS has undergone several physical relocations as a result of a remodeling project of the building and reorganization during the last twelve months. Understandably, with the physical activities of moving and changes in personnel, some records may be misfiled. We shall make every effort to improve our filing system

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-16: The Department For Medicaid Services Should Strengthen Controls Over Monitoring The Home And Community Based Waiver (Continued)

Management's Response and Corrective Action Plan (Continued)

The APA's comments relating to AD HOC Requests is not clear. Specifically, the APA seems to make a distinction between "...recipients indicated activity and "...recipients with paid claims...". DMS staff would be glad to meet with APA to gain an understanding of their issues.

- B. It is possible that some providers may have archived client files and did not have them readily available for the APA's review. Also, DMS did not review the information that was obtained from the provider before giving it to APA. Thus, we are not aware of the information that may be missing or incomplete. DMS would be glad to meet with the APA and review the documentation in an effort to determine if the APA's comments are valid.*
- C. It has been the understanding of the department that information can be retrieved from Unisys system by the date that the information was input into the system. The Division of Long Term care cannot determine if the Unisys system complies with the requirements of the RFP and related contract. Therefore, we will defer this response to the Division of Management Information Systems.*
- D. DMS will continue to work to ensure that the system provides ready access to HCB recipient assessment/reassessment records and related documentation. We are not clear as to the APA's recommendation that DMS investigate the validity of HCBW MMIS "eligibility data". DMS will continue to Monitor HCB recipient records to ensure completeness, accuracy and compliance with applicable laws and regulations through the on-site review process. We defer to the Division of Management Information Systems for a response to the APA's recommendation to investigate compliance with the Unisys contract. Last, DMS has always maintained an effective policy and procedures manual, including the audit period in question*

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-16: The Department For Medicaid Services Should Strengthen Controls Over Monitoring The Home And Community Based Waiver (Continued)

Auditor's Response

With respect to Management's findings regarding Comment A, we believe that DMS has an implied duty to maintain HCBW recipient files and/or a usable database for retrieving similar information. The APA found the Unisys database to be unusable and no hard-copy files were located within DMS for any of the recipients. Thus, it appears that DMS has very little interaction with these files. The only means of retrieving useful and comprehensive recipient data is through the various HCBW providers. Our comments regarding Provider #73 concerns evidence that this provider was billing for HCBW services but not listed on the MMIS database.

With respect to Management's findings regarding Comment B, we believe that DMS should have expedient, if not immediate, access to recipient files. Currently, DMS has neither. The only way to ensure that complete documentation is on file would be to visit each of the providers (100 during audit period). This is not a practical process for the APA or for DMS. DMS staff noted to auditor that, in years past, complete and accessible files were maintained at DMS. It remains unanswered as to why DMS has chosen not to maintain or review these files; however, the APA does not agree that file oversight is not required.

With respect to Management findings regarding Comment C, we received no response from the Division of Management Information Systems. We agree that certain data may be accessed by service date; however, access by MAID# and/or recipient name is necessary for complete and expedient information retrieval and appears to be mandated by the contract. We were not provided with any explanation (by Unisys of DMS) regarding why records could not be retrieved by more logical and conventional means. Auditor was directed to a DMS staff member by DMS Long-Term Care Management in order to access the Unisys "imaged data" system for HCBW recipients and the Unisys database could not be accessed in any fashion.

With respect to Management findings discussed in Comment D, we note that we requested, but were not provided, policy and procedures guidelines contemporaneous with the audit period.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-17: The Department For Mental Health/Mental Retardation Services Should Create A Written Policy And Procedure Manual Including Statistical Valid Sampling Procedures For On-Site Reviews Of The Supports For Community Living Waiver

Good internal controls provide for detailed policy and procedures guidelines for employees responsible for implementing the Supports for Community Living Waiver within the Department of Mental Health/Mental Retardation Services. Auditor was informed that a policy and procedures manual was in the "draft" stage and that none was available specific to the audit period July 1, 1997 through June 30, 1998. The *Supports for Community Living Manual* and the associated *Supports for Community Living Reimbursement Manual* are incorporated by reference in 907 KAR 1:145 which provides a descriptive template and legal nexus for implementation of the *SCL Manual*. Additionally, an Interagency Agreement between DMS and DMH/MRS segregates and further describes joint and individual duties of the two agencies. We conducted a frequency utilization review of the AIS/MR and SCL Waiver on-site review process. The reviews are conducted on selected providers and selected recipients throughout the audit period. We noted instances which may compromise the ability of DMH/MRS staff to effectively monitor persons enrolled in the SCL Waiver and/or determine eligibility, continued participation, and effective utilization of resources available under the Waiver. Our findings are as follows:

- We noted 8 on-site reviews were conducted during the AIS/MR Waiver period (July 1, 1997 through August 31, 1997) and 12 on-site reviews were conducted under the SCL Waiver period under review (September 1, 1997 through June 30, 1998). We noted that no summary data was available to verify completeness of the on-site review process. Additionally, there were no policies and procedures made available to the auditor which substantiated a reasonable basis for the review selection criteria, frequency of reviews, and selection of recipients. There also seemed to be no forthright or clear segregation of duties and recordkeeping responsibilities during the AIS/MR to SCL Waiver transition period in that the DMS files contained a number of SCL reviews (after August 31, 1997). Additionally, no population of recipients was noted for each of the on-site reviews at the time of the review.
- In that there were no written policy and procedures guidelines available for establishing a basis for the on-site review selections, there was no documentation that the on-site reviews conducted represented a reasonable selection of the population of providers and recipients enrolled in the waiver program. If the number of reviews conducted is not sufficient, DMH/MRS cannot be assured that all of the persons enrolled in the program are adequately serviced and that the providers are complying with obligations outlined in the SCL Waiver Manuals.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-17: The Department For Mental Health/Mental Retardation Services Should Create A Written Policy And Procedure Manual Including Statistical Valid Sampling Procedures For On-Site Reviews Of The Supports For Community Living Waiver (Continued)

Medicaid funds that are paid to states by the federal government are considered federal awards expended and are covered under the Single Audit Act Amendments and OMB Circular A-133. DMH/MRS must establish and maintain internal controls designed to reasonably ensure compliance with federal laws, regulations, and program compliance requirements. Additional requirements regarding roles and responsibilities of DMH/MRS are discussed in 907 KAR 1:145, and the *Supports for Community Living Manual* incorporated therein, the associated *Supports for Community Living Payment Rate Determination Manual*, and the *Interagency Agreement between the Department for Medicaid Services and the Department for Mental Health/Mental Retardation Services*. A good internal control structure and well-defined policy and procedures are essential for the achievement of full accountability and compliance with applicable laws and regulations. Additionally, timely access to records is crucial to an audit and DMH/MRS.

Recommendation

We recommend the DMH/MR create and implement an effective policy and procedures manual that encompasses the on-site review process. These policies and procedures should ensure that DMH/MRS maintain recipient population data for each provider and implement a process to include a statistically valid sample of a given provider's clients and the aggregate population of providers in the on-site review process. DMH/MRS should maintain a historical summary of the reviews and document the population of recipients at the time of the review.

Management's Response and Corrective Action Plan

DMS has always maintained an effective policy and procedures manual, including the audit period in question. The SCL Waiver does not require an on-site review process. On-site reviews are a voluntary internal control tool that is used by DMS to ensure the health and safety of SCL Waiver participants. DMS shall work to ensure that the sample is as statistically valid as possible. DMS shall continue to conduct on-site reviews as time permits.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-17: The Department For Mental Health/Mental Retardation Services Should Create A Written Policy And Procedure Manual Including Statistical Valid Sampling Procedures For On-Site Reviews Of The Supports For Community Living Waiver (Continued)

Auditor's Response

We believe the health and safety of SCL Waiver recipients is best facilitated by well planned, documented and statistically sound on-site reviews of waiver providers and recipients and that DMH/MRS, has an implied, if not expressed, duty to conduct the reviews and report them in a verifiable manner. Given the high, per-recipient cost of this waiver, we do not agree that the on-site reviews should be relegated to a "time permitting" or "voluntary" process. The auditor noted health and safety issues involving recipient sexual and physical abuse and two accidental death investigations by the Council within the audit period. Given the high-risk status of the recipients, we believe the on-site reviews conducted by DMH/MRS, along with provider reviews (of the sort formerly performed by the Council) during the audit period, are an important and necessary for proper oversight of the SCL Waiver.

FINDING 98-CHS-18: The Department For Medicaid Services Should Ensure That Ad Hoc Reports From Unisys Are Timely And Accurate

During our initial testing of 5 Fraud and Abuse cases at the Attorney General's office, we did not note any difficulties in receiving accurate and timely Ad Hoc reports. However, through discussion with personnel, it was noted that there is a problem in receiving Ad Hoc reports in a timely manner and obtaining accurate data. This is a repeat comment from prior year.

The Attorney General's office started an Ad Hoc Tracking sheet in January 1998. The auditor obtained this information. Due to finding that there is still a problem with Ad Hoc reports being received in a timely manner and being accurate, the auditor decided to extend testing to include testing the accuracy of the Ad Hoc Tracking sheet. Information such as a copy of an Ad Hoc request and copies of reports received was obtained from the Attorney General's office. This documentation obtained appears to be accurate to what is documented on the Ad Hoc Tracking sheet. Therefore, it appears that Ad Hoc reports are not being obtained in a timely manner, nor is the information accurate.

Without reliable data, investigators are not able to complete their work on the complaints received. When complaints are opened to a case, attorneys depend on timely, accurate reports to prepare for trial. Difficulties with Ad Hoc reports are hindering investigators in researching cases and attorneys in preparing for prosecution.

Requirements for the timeliness of Ad Hoc reporting is specifically outlined in the Request for Proposal (RFP) with UNISYS (Section 5.26.22). Accuracy of Ad Hoc reporting is addressed in Section 3.6.23.2.4, and the RFP states that UNISYS should "ensure that data provided through the Ad Hoc reporting function is correct, internally consistent, and consistent with comparable data used In other MMIS functions and reports."

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-18: The Department For Medicaid Services Should Ensure That Ad Hoc Reports From Unisys Are Timely And Accurate (Continued)

Recommendation

We recommend that DMS ensure that UNISYS fulfills contractual responsibilities. DMS needs to secure timely and accurate reports from UNISYS to enable MFCU to research fraud and abuse cases.

Management's Response and Corrective and Plan

The Department for Medicaid Services recognizes our responsibility to assure that Unisys provides accurate and on-time reports to the Attorney General's Office as well as to all entities requesting data from our system. Unisys has changed their Ad Hoc reporting structure in order to more fully comply with current contract requirements. Changes include the addition of seven (7) additional programmers dedicated to ad hoc reporting until the backlog of all ad hocs is reduced to current entries. Additionally, a senior analyst has been assigned to review all new ad hocs in order to ensure requests are clear and concise with regard to what is being requested. In addition to changes made at Unisys with regard to current requirements, the DMS and Unisys are implementing a new Decision Support System based on Data Base technology with new reporting software that will make retrieval faster and available to a wider group of people. During the Summer, we plan to offer the Attorney General's office this new retrieval system so they can request data independent of DMS. Of course, they will still be able to utilize DMS as a conduit for their ad hoc requests if desired.

FINDING 98-CHS-19: The Department For Medicaid Services Should Implement A System To Generate Random Selection Of Edit Check Denied Claims In The Medicaid Management Information System

Good internal controls provide for verifiable and accurate data retrieval capability from within the Unisys Medicaid Management Information System. For the AIS/MR/SCL Waiver Program and the HCB Waiver Program, we reviewed seven edit check provisions of the MMIS system used for the two waivers. Our test was for completeness of records. Of these seven edit functions, we selected April 1998 and December 1997 for testing. The sample totaled 232 specific Transaction Code Numbers (TCN). We specified our sample by Ad Hoc Report and requested that certain of the edit code selections (those with over seven denied services) be randomly selected. Our findings follow:

- DMS was able to source all but 2 of the 232 denied services from Unisys, the contracted data maintenance agent. We contacted the Ad Hoc records facilitation staff member at Unisys Corporation responsible for the sample records and were unable to determine that the specified random selection was truly randomly generated. Instead, the process was ultimately left to the judgement of Unisys staff that provided the denied claims.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-19: The Department For Medicaid Services Should Implement A System To Generate Random Selection Of Edit Check Denied Claims In The Medicaid Management Information System (Continued)

Without assurance of random sample generation, we have no way to verify completeness of records. In that the TCN cannot be sequentially selected, we were unable to generate verifiably random selections by using a system of our own design. Therefore, we relied on DMS and/or Unisys to provide the random selection. A check of records completeness for the edit process must necessarily include verifiable parameters of random selection if we are to be assured that Unisys is not selectively choosing denied services for which it knows records are available.

Medicaid funds that are paid to states by the federal government are considered federal awards expended and are covered under the Single Audit Act Amendments and OMB Circular A-133. DMS must establish and maintain internal controls designed to reasonably ensure compliance with federal laws, regulations, and program compliance requirements. A good internal control structure and well-defined policy and procedures are essential for the achievement of full accountability and compliance with applicable laws and regulations. Paramount to the provider payment verification process is the facilitation and monitoring of MMIS data. DMS is responsible for administering the MMIS in order to ensure that proper payments are provided. It is crucial that the APA be given full access to complete and verifiable records related to the MMIS system.

Recommendation

We recommend DMS implement a system that will provide the APA ready access to the MMIS system and random generation of MMIS edit check denied claims.

Management's Response and Corrective Action Plan

DMS has researched the "Nature of the Weakness Or Noncompliance" section of the audit, and agree with the statements regarding the sampling procedure methodology. However, DMS believed the pulled sample was in accordance with the auditor's directions. The Auditor described the ad hoc that was needed, and a special run was made to isolate the TCN's of waiver claims denied for any of the seven (7) specifically defined errors. The time frames requested was for April 1998, and December 1997. The report output was checked to assure the claims pulled met the requested criteria. Once this had been validated, a manual random sample was pulled from the universe of all claims for each error. The sample was selected based on the following criteria: if there were under seven (7) errors, then select all claims; and if more than seven (7) errors, then randomly pull seven (7) claims from that universe. After the TCN's of the sample were selected, those TCN's were given to the Unisys work group who have the responsibility for pulling claims and RA's. The fact that the TCN's were identified systematically, and then a "division of labor" utilized (in that the sample selector did not also pull the associated documentation), appeared to be within the parameters of the request to DMS.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-19: The Department For Medicaid Services Should Implement A System To Generate Random Selection Of Edit Check Denied Claims In The Medicaid Management Information System (Continued)

Management's Response and Corrective Action Plan (Continued)

Modifications could be made to the MMIS that would fully automate this process. However, given that this is a yearly process, DMS will mimic the process as used this year with the exception that DMS staff or the Auditor's staff will be given the list of TCN's to make the random sample selection.

Auditor's Response

Auditor notes that concerns regarding the ability of Unisys to provide random test selections were addressed to DMS staff prior to and during the Ad Hoc action. DMS required that we make our test sample selection through the Ad Hoc retrieval process. No alternative selection strategy was suggested for narrowing or verifying the parameters of the request. Without access to the list of TCN population the APA cannot be assured that the sample is randomly selected.

FINDING 98-CHS-20: The Department For Public Health Should Develop A Formal Disaster Recovery Plan

As was noted during the previous audit, the Department for Public Health (DPH) did not have a complete business recovery plan in effect during the 1998 fiscal year for their local computing facilities.

Not having a complete business recovery plan increases the possibility of loss due to excessive recovery time and costs, and disruption of DPH processing capabilities.

Good management practices minimize risks through planning. The goal of a business recovery plan is to improve preparedness and recover normal operations at minimal cost using available resources.

We are aware that some of the information recommended as additions to the business recovery plan already exist. However, for it to be of use during a disaster the information must be in one location for quick reference. A centralized plan facilitates review and revision of pertinent information, which should be performed on a regular basis. This plan should be distributed to all emergency personnel and all distributed copies kept up-to-date.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-20: The Department For Public Health Should Develop A Formal Disaster Recovery Plan (Continued)

Recommendation

We recommend that the a business recovery plan be developed, which should include, at a minimum, the following:

- Identification of emergency personnel and contact numbers
- Identification of critical data and software
- Listing of vendor contacts with whom agreements have been made for obtaining emergency equipment replacement
- Specific procedures to be followed for business recovery during various levels of disaster or downtime
- Backup or manual procedures to be followed for business continuity in the case of extended disruption and/or the inability to use normal facilities
- Annually updated documentation of agreements with the Department of Information Systems
- Training of emergency personnel
- Annual testing of the recovery plan

In addition, we recommend that this plan be distributed to all emergency personnel and updated periodically.

Management's Response and Corrective Action Plan

The Department for Public Health, Information Technology Branch, is in the process of preparing a Business Recovery Plan for its network-computing environment. This Plan focuses on the recovery of the microcomputer and Local Area Network (LAN) of which the Department solely depends on for its daily operations.

The Information Technology (IT) Branch has implemented the following:

- ❑ **IT Recovery Team** (Consisting of the IT Manager and Network Engineers)
IT Department personnel notification checklist is maintained by the IT Branch in order to notify staff of the activation of the Recovery Plan and to advise them as to what they are supposed to do. This includes: name of employee, job title, home phone, car phone, pager number, and home address with directions.
- ❑ **Computer Equipment Inventory**
The IT Branch maintains a complete inventory of all computer equipment on the LAN. This inventory identifies the type of computer equipment, model, vendor, serial number and the name of the individual assigned the equipment.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-20: The Department For Public Health Should Develop A Formal Disaster Recovery Plan (Continued)

Management's Response and Corrective Action Plan

- ❑ **Computer Supplies Inventory**
The IT Branch maintains a complete inventory of all computer supplies. This inventory is used to determine which supplies are undamaged and which supplies are destroyed and must be replaced.
- ❑ **Computer Software Inventory**
The IT Branch maintains a complete inventory of all computer software on each server and workstation which includes vendor, version, and licensing agreement.
- ❑ **Database Inventory**
The IT Branch maintains a complete inventory of all databases housed on the Department's LAN.
- ❑ **Computer Hardware System Integrators**
The IT Branch maintains a listing of computer hardware vendors on State Price Contract with the Commonwealth.
- ❑ **LAN System Backups**
The IT Branch conducts full systems backups on a daily basis. Backup tapes are stored in a fire-proof storage cabinet. Using the backup files provides day-to-day recovery of data files. The Department is pursuing the lease of a bank lock box for off-site storage.

The Department is identifying requirements for a temporary location facility for its network-computing environment. Requirements include responsibilities, procedures, checklists, and forms that will be used to manage and control the recovery of essential computer operations following a disaster.

FINDING 98-CHS-21: The Commission For Children With Special Health Care Needs Should Adhere To Established Internal Control Procedures

CCSHCN did not consistently adhere to established internal control procedures. This was a prior year weakness, which is being repeated. It should be noted that the prior year weakness was delivered in July of 1998, after the period of this audit. As a result, we again noted the following exception within the reporting section of testing internal controls. In our test of internal control over reporting, we noted that the CCSHCN daily report was not initialed after reconciliation. As indicated in the prior year, all daily reports reconciled after January 30, 1997 were not checked off and initialed. This was addressed and was just an oversight due to some changes that were made. The Accountant Principal now keeps a running total of all pending documents on the computer. She will deduct the document once it is no longer pending and this will be reflected on the pending file. She keeps a folder of all pending documents and once a document is paid she pulls it from the folder and deducts it from her running total. However, the Accountant Principal was no longer checking each document as it was pulled and recorded for the year ended June 30, 1998.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-21: The Commission For Children With Special Health Care Needs Should Adhere To Established Internal Control Procedures (Continued)

This could lead to a miscalculation due to each document not being checked off. A document could be overlooked and remain in pending status when it actually is no longer pending. This could lead to a misstatement of the pending file folder.

For proper internal control, there needs to be effective reconciliation of expenditures to STARS. There also needs to be proper documentation of this procedure. Without this documentation, there is no verification that such reconciliation was done.

Recommendation

As in the prior year, we continue to recommend that CCSHCN documents listed on daily report are checked off and the pending file total is attached. The Accountant Principal should check each document and update the pending file folder. A printout of the reconciliation performed on the computer should be attached to the daily report with their initials. This would document the reconciliation and the person who performed the reconciliation. Also, a total of the actual pending for that day would be available if someone needed to look back on a certain day.

Management's Response and Corrective Action Plan

As noted in the auditor's report this is a prior weakness on the previous audit. This weakness was originally cited in July 1998. The audit exception was noted after the period of the current audit, and thus would be expected to occur in the current audit. After the weakness was originally reported the accountant Principal was instructed to initial and check all documents that recorded on the daily reports. This procedure is currently in place and when the audit for FY99 is performed will not be cited as a continuing weakness.

**CABINET FOR HEALTH SERVICES
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE YEAR ENDED JUNE 30, 1998
(CONTINUED)**

SECTION 3 – FEDERAL AWARD FINDINGS AND QUESTIONED COSTS (Continued)

Other Matter Comments Relating To Internal Control And Compliance: (Continued)

FINDING 98-CHS-22: The Department Of Public Health Should Improve Controls Over The Special Supplemental Nutrition Program For Women, Infants, And Children

The bank statements for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) bank account are properly reconciled each period; however, supervisory personnel do not review the reconciliation.

Management does not have knowledge that the agency's bank accounts have been reconciled and are accurate. Since WIC payments received and paid by the bank initiate most of the expenditures and program drawdowns, errors or mistakes in the reconciliation process could directly affect the program's expenditures and drawdowns.

Good internal control practices and segregation of duties would dictate that bank statement reconciliation should be reviewed and approved by a supervisor.

Recommendation

We recommend the Department for Public Health, Division of Adult and Child Services, Resource Management Branch initiate supervisory reviews of program bank statement reconciliation.

Management's Response and Corrective Action Plan

The Department for Public Health agrees with the finding regarding review of bank reconciliation for the WIC program. During FY 1998, staff performing the WIC bank reconciliation were transferred to the Division of Resource Management and assigned new supervisors. The current supervisor will now review and approve all monthly bank reconciliation for the WIC program effective immediately.

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SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

**CABINET FOR HEALTH SERVICES
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
FOR THE YEAR ENDED JUNE 30, 1998**

Fiscal Year	Finding Number	Finding	CFDA Number	Questioned Costs	Comments
(1) Audit findings that have been fully corrected:					
<u>Reportable Conditions</u>					
FY 97	97-CHS-1	The Cabinet for Health Services Should Strengthen Controls Over Estimation of Contingent Liabilities	N/A	0	The agency has improved their procedures to calculate estimates of loss and estimates of probability of loss for contingencies.
FY 97	97-CHS-45	The Department For Medicaid Services Should Improve Controls Over The Accounts Receivable Function	N/A	0	Controls over the Accounts Receivable Function have been improved.
<u>Material Conditions</u>					
FY 97	97-CHS-56	The Department For Public Health Should Ensure All Modifications Are Completed To Allow Processing In The Year 2000	N/A	0	Year 2000 compliance conversion has been completed for the WIC Program.
(2) Audit findings not corrected or partially corrected:					
<u>Reportable Conditions</u>					
FY 97	97-CHS-44	The Department For Medicaid Services Should Improve The Controls Over Drug Rebate Billings, Collection, and Recording.	N/A	0	Two of the four recommendations have been implemented. One is partially resolved. The agency has contracted with two businesses to resolve the backlog of drug rebate discrepancies.
FY 97	97-CHS-46	The Department For Medicaid Services Should Ensure That The State Worker's Compensation Data Exchange Occurs Between The Labor Cabinet And The Department For Medicaid Services	N/A	0	No improvement was made to this comment during FY 98. The agency is implementing these recommendations for FY 99.

**CABINET FOR HEALTH SERVICES
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
FOR THE YEAR ENDED JUNE 30, 1998**

Fiscal Year	Finding Number	Finding	CFDA Number	Questioned Costs	Comments
(2) Audit findings not corrected or partially corrected (continued):					
<u>Reportable Conditions</u> (Continued)					
FY97	97-CHS-47	The Finance And Administration Cabinet And The Cabinet For Health Services Should Develop Procedures To Ensure Vendors Providing Services To Federal Programs Are Not Debarred Or Suspended By The Federal Government	N/A	0	MARS will have the capability to identify debarred/suspended vendors. The agency will implement this finding July 1, 1999.
FY 97	97-CHS-48	The Division Of Substance Abuse Should Adhere To Established Internal Control Procedures	N/A	0	A log is now maintained of all progress reports. However, reminders need to be sent when reports are not received within 30 days. The agency is implementing this in FY99.
FY 97	97-CHS-49	The Department For Public Health Should Develop A Complete Information System Security Policy.	N/A	0	The agency has made progress toward complying with audit recommendations, but has yet to fully implement corrective action plan. Exceptions were again noted during the FY 98 review.
FY 96	N/A	The Department For Medicaid Services Should Improve Internal Controls Relating To The Alternative Intermediate Care/Mental Retardation Waiver	N/A	\$120,760	The agency implemented our corrective action plan for FY 97. However, the questioned cost has not been resolved.

**CABINET FOR HEALTH SERVICES
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
FOR THE YEAR ENDED JUNE 30, 1998**

Fiscal Year	Finding Number	Finding	CFDA Number	Questioned Costs	Comments
(2) Audit findings not corrected or partially corrected (continued):					
<u>Material Conditions</u>					
FY 97	97-CHS-54	The Department For Medicaid Services Should Develop Controls To Monitor The Third Party Liability Function Performed By the Fiscal Agent	N/A	0	The agency has implemented 3 of 4 recommendations for FY 98. Our last recommendation will be implemented for FY 99.
FY 97 FY 98	97-CHS-55	The Department For Medicaid Services Should Establish Procedures To Ensure That Pharmacy Provider Information Is Accurate And Current In The Medicaid Management Information System	N/A	184,633 302,180	Controls were not fully implemented for FY 98. Re-enrollment is underway and other procedures are being developed to update and ensure the integrity of the MMIS.
Total Questioned Costs				\$486,813	

(3) Corrective action taken is significantly different from corrective action previously reported:

Not applicable.

(4) Audit finding is no longer valid:

Not applicable.